MATERNITY IMPROVEMENT PROGRAMME
HIGHLIGHT REPORT – Safe & Effective Care Project

Completed by	Director of Midwifery, Gynaecology and Sexual Health/ Maternity Programme Improvement Manager	**Reporting period:**	February 2020	**To :**	March 2020
Date Completed:	14/04/2020		**Next Review Meeting:**	**18/05/2020**	
Current status	**Headlines:**				
R A G	• Details of recommendations agreed and signed off at IMSOP assurance visit held on 18/02/2020 and from further evidence submitted 09/03/2020 • Future suggested actions				

Key Achievements This Quarter	**Project Plan: Proposed Achievements Next Quarter**
<u>IMSOP validated and approved the following recommendations – 18/02/2020 & 23/03/2020.</u> • **DU Report (1, 2019):** Use learning to inform improvement via the newly developing governance arrangements – ***verified 18/02/20*** six monthly review to panel • **DU Report (2, 2019):** Complete the reviews of 43 incidents **-** ***verified 18/02/20*** as these cases now fall under the clinical review process and are no longer being investigated by the HB • **DU Report (3, 2019):** Ensure governance process are consistent – ***verified 23/03/20*** six monthly review to panel • **Rec 7.11:** Mandatory meetings – ensuring attendance of all key staff – **verified 18/02/20 HB to monitor** • **Rec 7.14:** Consultant meetings are regular in frequency – **verified HB to monitor** • **Rec 7.16:** Obstetric consultant availability – **verified 23/03/20** with exception reports to future panel • **Rec 7.21:** Improve incident reporting **- verified 18/02/20** with quarterly review to panel	• **DU Report** – further evidence required on training undertaken with regards to incidents, • **DU Report** – Simply the current process for review of an incident • **Rec 7.1**– progress the review of systems in place for data collection and validation • **Rec 7.2 –** Review of all Maternity Unit guidelines to ensure a multidisciplinary approach • **Rec 7.19, 7.21, 7.23, 7.51** – PTR process in relation to concerns, claims, patient safety incidents, • **Rec 7.55** – Review effectiveness of bereavement services

• **Rec 7.27:** Consider extra resource to the Maternity Governance Team- **verified 18/02/20** with quarterly review to panel • **Rec 7.66** – Updated risk register & review regularly at Board - **verified 09/03/20 HB to monitor**	
Recommendations verified on 16/12/19 which are now considered closed:	
Rec: 7.4, 7.9, 7.10, 7.12, 7.23, 7.26, 7.36, 7.38, 7.59, 7.60, 7.61, 7.65	

Self-Assessment Against Maturity Matrix

The Health Board is able to evidence <u>early progress</u> against the maturity matrix:

- ✓ The health board has a developing quality governance structure and has full engagement from all of the MDT.
- ✓ The health board has a developing quality dashboard and monitors key indicators.
- ✓ Clinical incidents are reported and investigated appropriately and learning is focussed on individual incidents. Changes in practice are recommended but there is limited evidence that these changes are implemented and/or impact on future safety.
- ✓ Responsibility for patient safety and governance is limited to a few key individuals in the maternity service.

Slippage and remedial action	**Issue or concerns**
RCOG Rec 7.7: Ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage	Significant work has been undertaken in the form of: • Development of a business case • Identifying a dedicated space on the PCH site • escalation to the Head of Midwifery/Service Group General Manager • Flagged on the risk register This is currently no available space on the PCH Site.

Monthly Maternity Monitoring Indicators - March 2010

PCH = Prince Charles Hospital Obstetric Unit, Tair Afon Birth Centre, Home (Cynon and Merthyr localities) and other (births in transit from Cynon and Merthyr localities)

POW = Princess of Wales Hospital Obstetric Unit, Bluebell Suite, Room 3, Ward 12, Home (Bridgend locality) and Born in Transit.

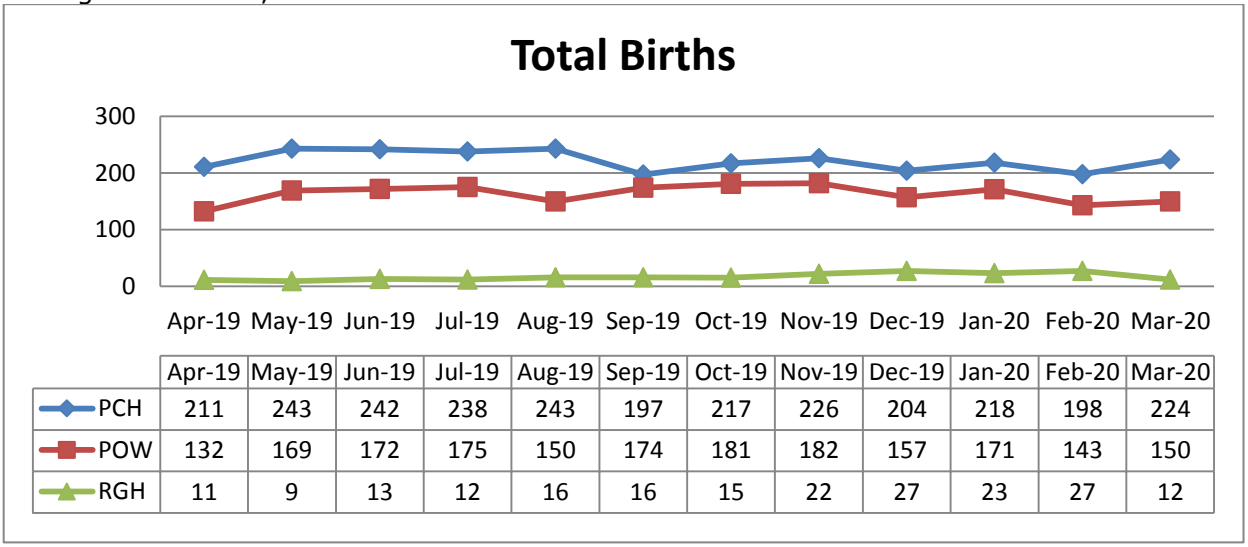
RGH = Tirion Birth Centre at the Royal Glamorgan Hospital, Home (Rhondda and Taff localities) and other (births in transit from Rhondda and Taff localities)

Births = babies born

Women = women delivering

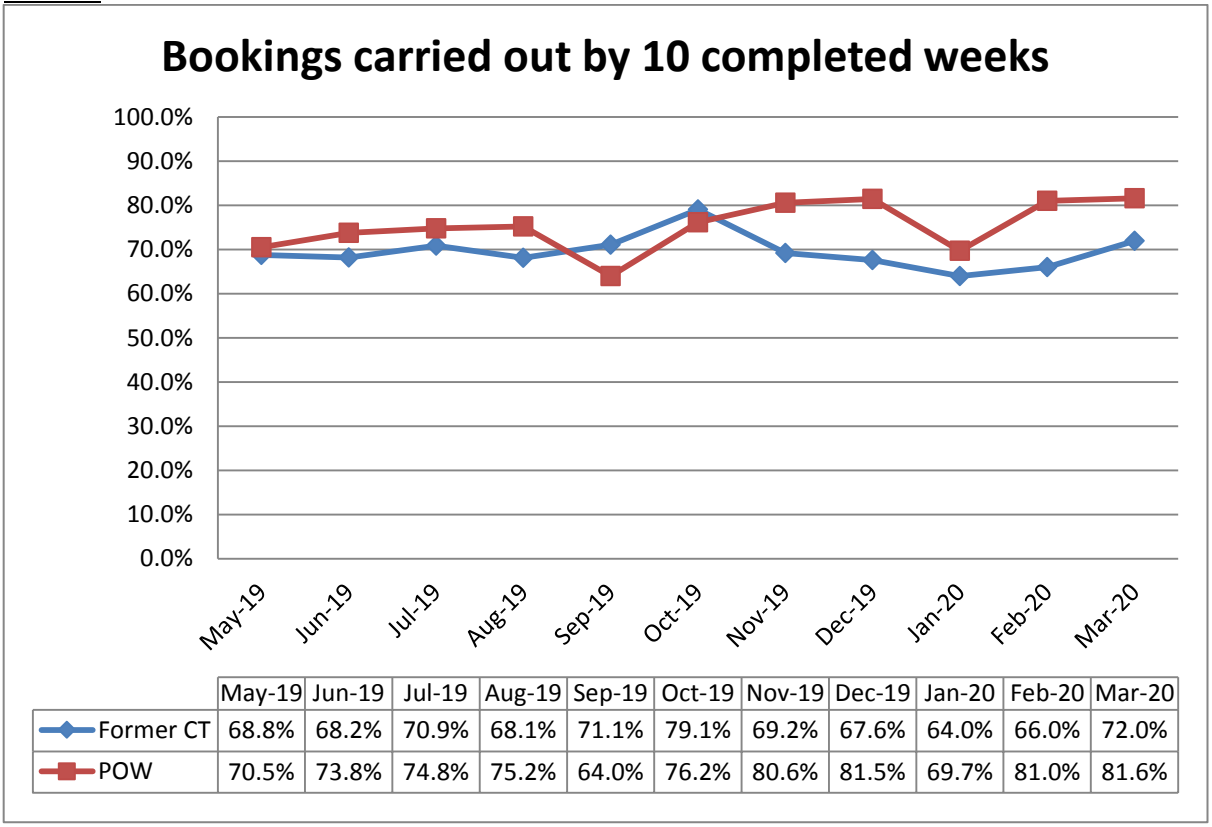
Total Births

During March 2020, there were 7 sets of twins born to 380 women.



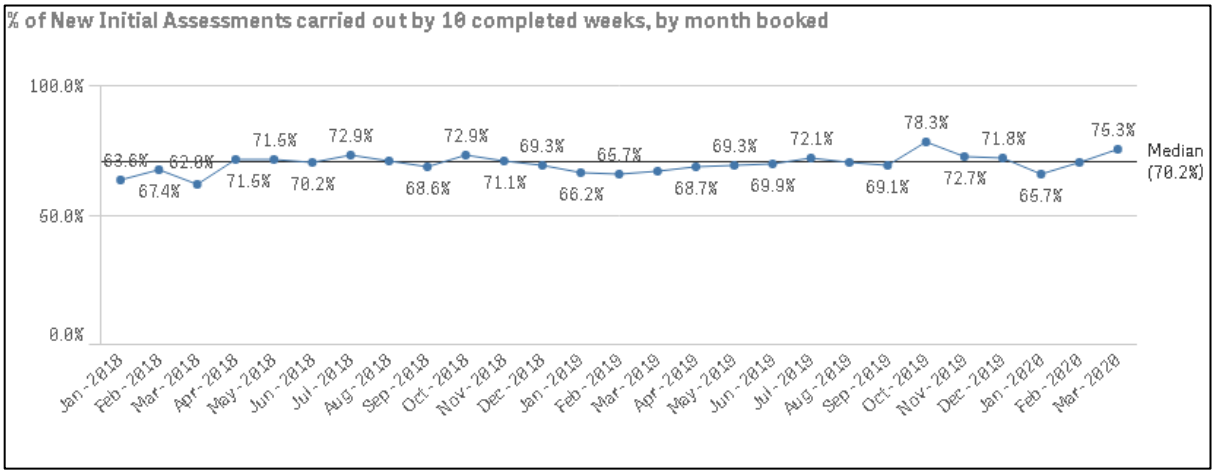
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	211	243	242	238	243	197	217	226	204	218	198	224
POW	132	169	172	175	150	174	181	182	157	171	143	150
RGH	11	9	13	12	16	16	15	22	27	23	27	12

% of New initial Assessments carried out by 10 completed weeks, by month booked



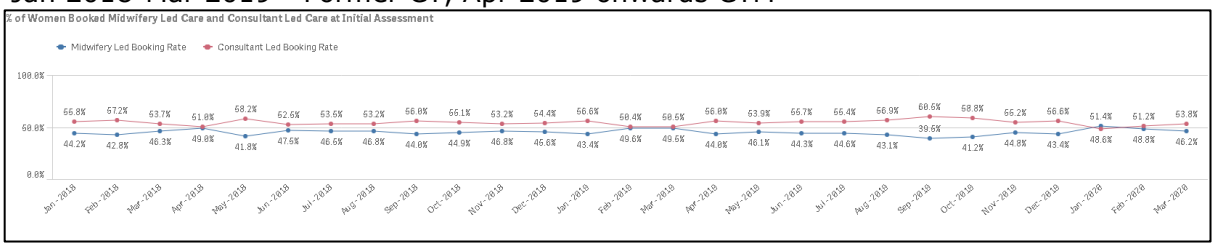
	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Former CT	68.8%	68.2%	70.9%	68.1%	71.1%	79.1%	69.2%	67.6%	64.0%	66.0%	72.0%
POW	70.5%	73.8%	74.8%	75.2%	64.0%	76.2%	80.6%	81.5%	69.7%	81.0%	81.6%

Run chart going back to 2018 - Jan 2018-Mar 2019 - Former CT, Apr 2019 onwards CTM



Midwifery and Consultant Led Care at Initial Assessment

Jan 2018-Mar 2019 - Former CT, Apr 2019 onwards CTM

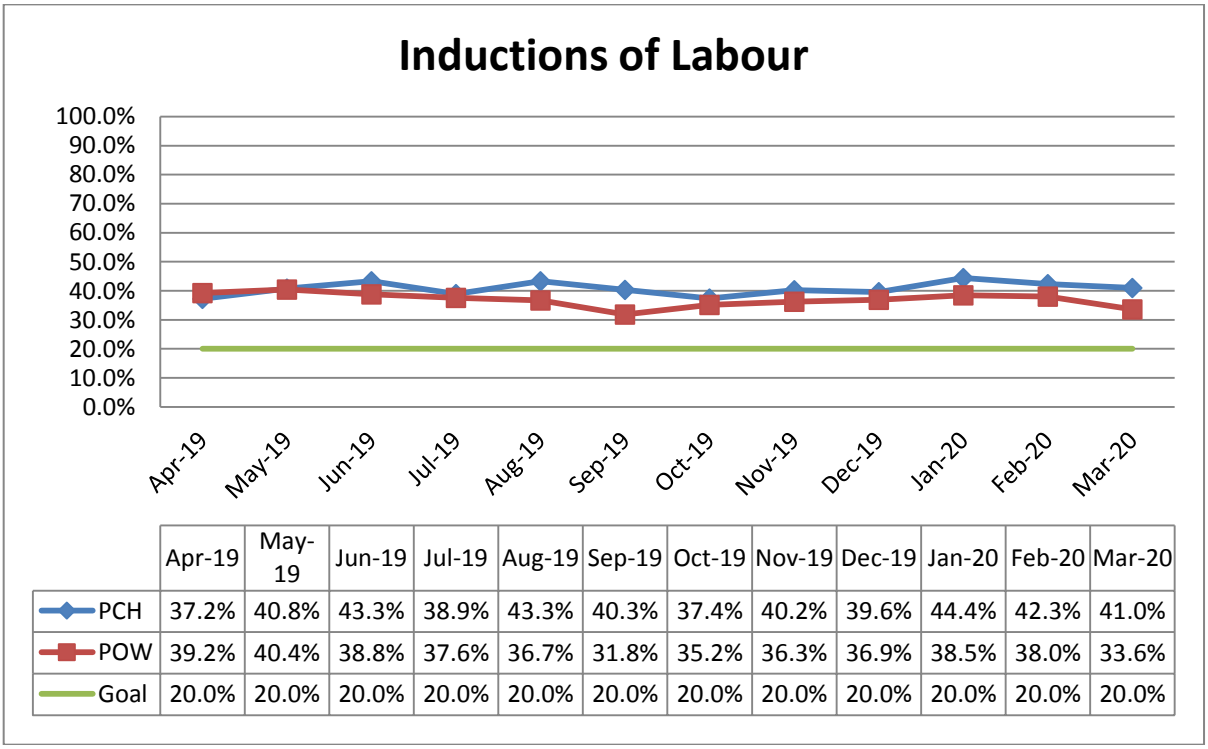


Inductions of Labour

Numerator: Total number of women induced

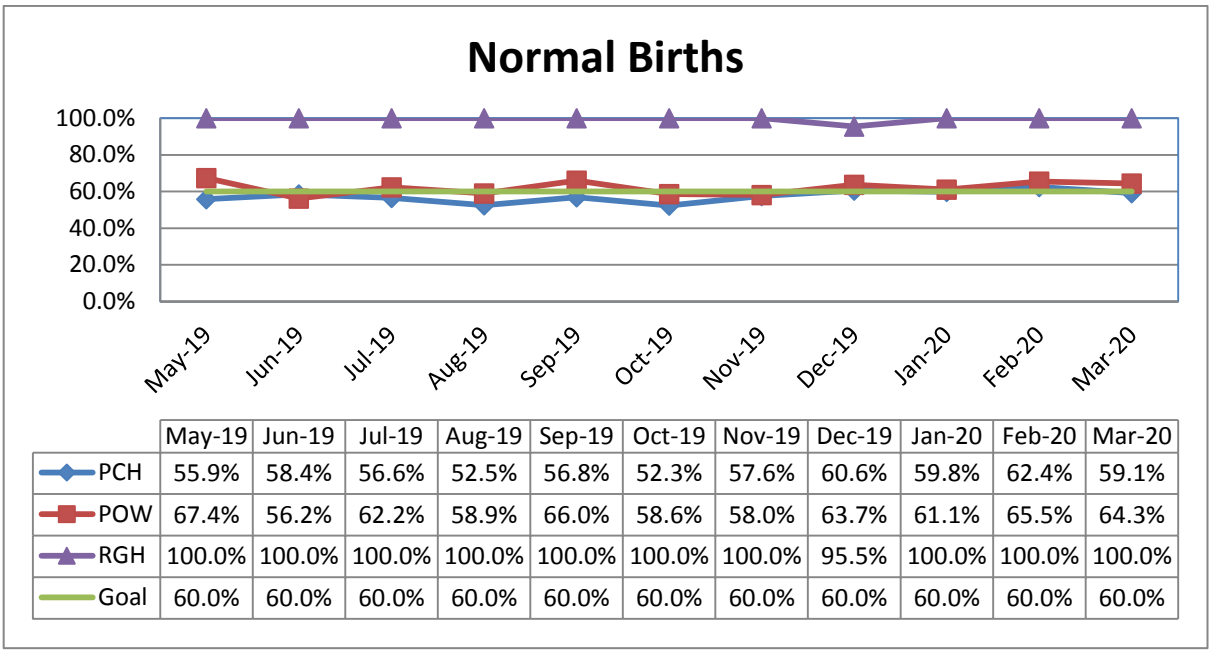
Denominator: Total number of women delivering

Goal: 20.0%



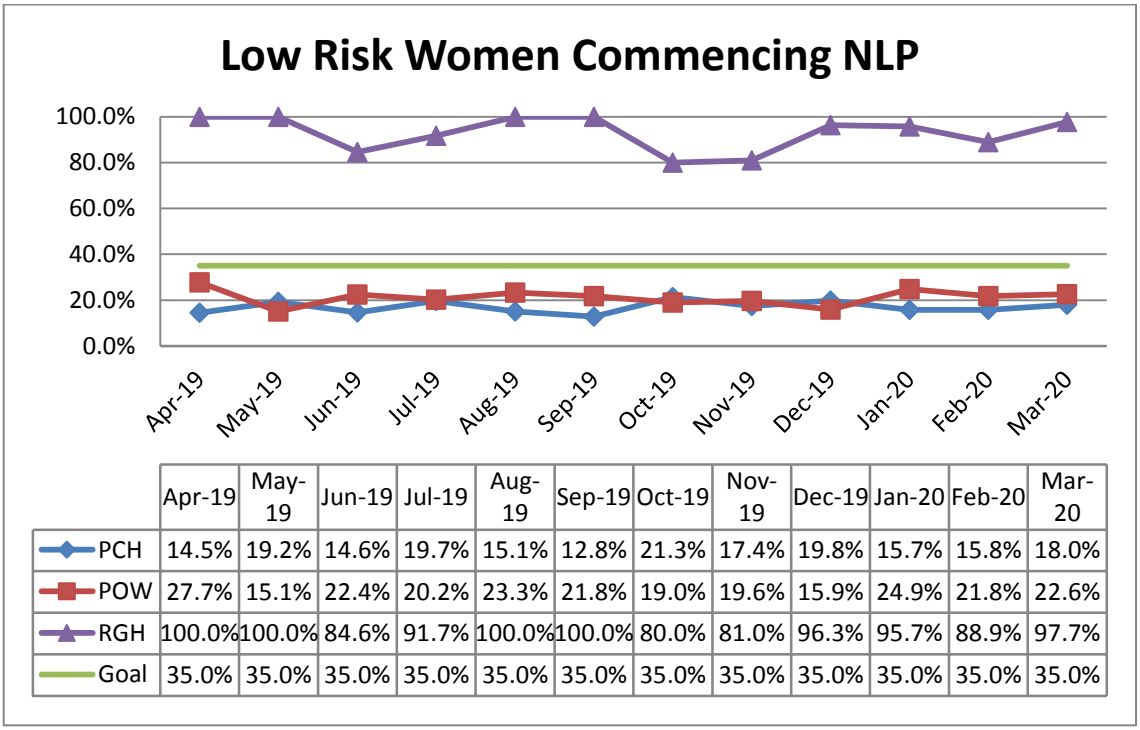
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	37.2%	40.8%	43.3%	38.9%	43.3%	40.3%	37.4%	40.2%	39.6%	44.4%	42.3%	41.0%
POW	39.2%	40.4%	38.8%	37.6%	36.7%	31.8%	35.2%	36.3%	36.9%	38.5%	38.0%	33.6%
Goal	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%

Normal Births
Numerator: Total number of SVD births
Denominator: Total number of births
Goal: 60.0%



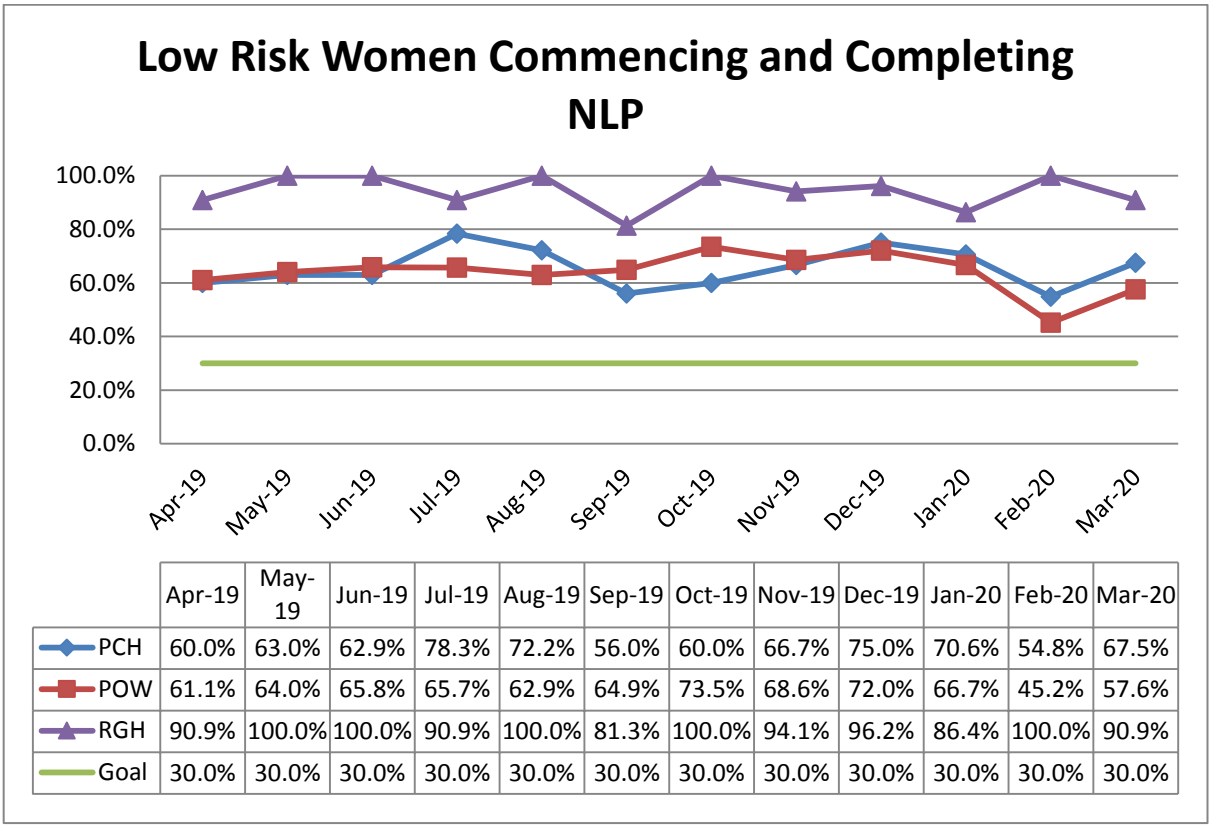
	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	55.9%	58.4%	56.6%	52.5%	56.8%	52.3%	57.6%	60.6%	59.8%	62.4%	59.1%
POW	67.4%	56.2%	62.2%	58.9%	66.0%	58.6%	58.0%	63.7%	61.1%	65.5%	64.3%
RGH	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%
Goal	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%

Low Risk Women Commencing NLP
Numerator: Total number of women commencing NLP
Denominator: Total number of women delivering
Goal: 35.0%



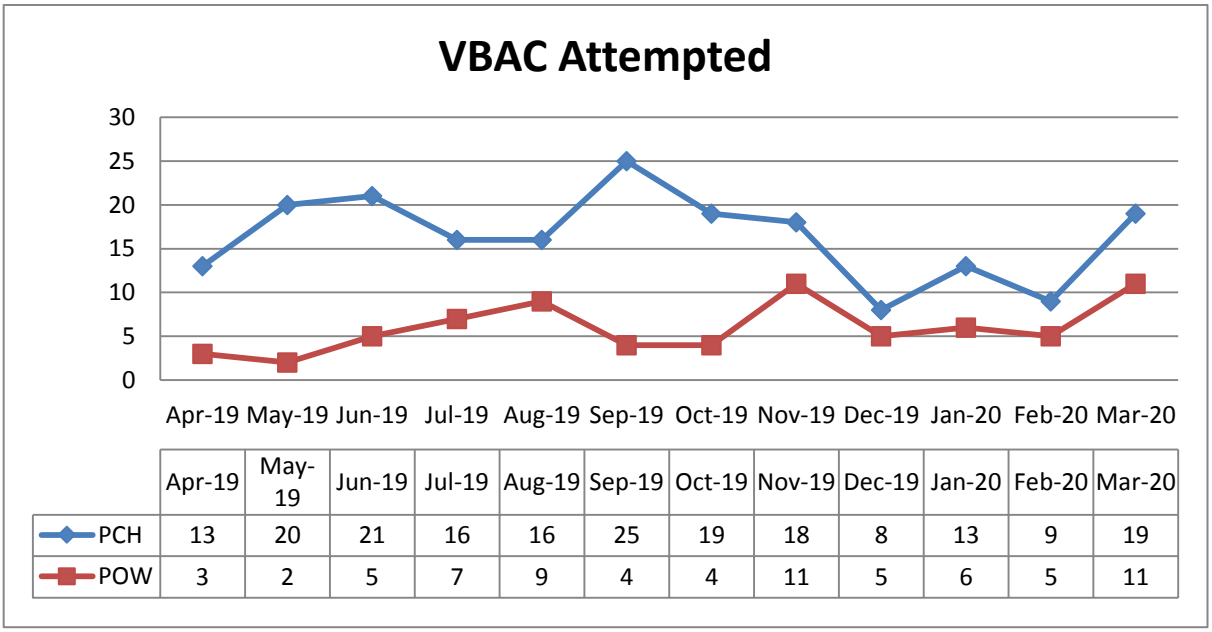
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	14.5%	19.2%	14.6%	19.7%	15.1%	12.8%	21.3%	17.4%	19.8%	15.7%	15.8%	18.0%
POW	27.7%	15.1%	22.4%	20.2%	23.3%	21.8%	19.0%	19.6%	15.9%	24.9%	21.8%	22.6%
RGH	100.0%	100.0%	84.6%	91.7%	100.0%	100.0%	80.0%	81.0%	96.3%	95.7%	88.9%	97.7%
Goal	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%

Low Risk Women Commencing and Completing NLP
Numerator: Total number of women completed NLP
Denominator: Total number of women commenced NLP
Goal: 30.0%



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	60.0%	63.0%	62.9%	78.3%	72.2%	56.0%	60.0%	66.7%	75.0%	70.6%	54.8%	67.5%
POW	61.1%	64.0%	65.8%	65.7%	62.9%	64.9%	73.5%	68.6%	72.0%	66.7%	45.2%	57.6%
RGH	90.9%	100.0%	100.0%	90.9%	100.0%	81.3%	100.0%	94.1%	96.2%	86.4%	100.0%	90.9%
Goal	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%	30.0%

VBAC Attempted:
Total number of women with a previous CS delivering by all modes, except category 4 CS. No goal set



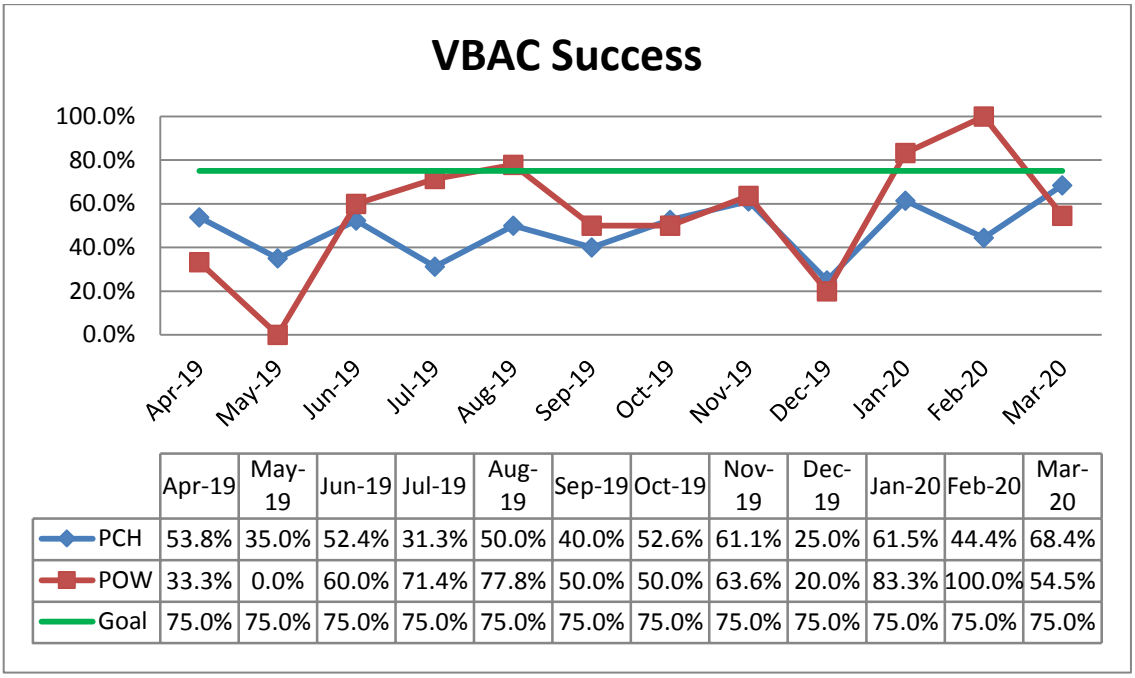
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	13	20	21	16	16	25	19	18	8	13	9	19
POW	3	2	5	7	9	4	4	11	5	6	5	11

VBAC Success

Numerator: Total number of women with a previous CS delivering vaginally

Denominator: Total number of women with a previous CS delivering by all modes except Category 4 CS

Goal: 75.0%



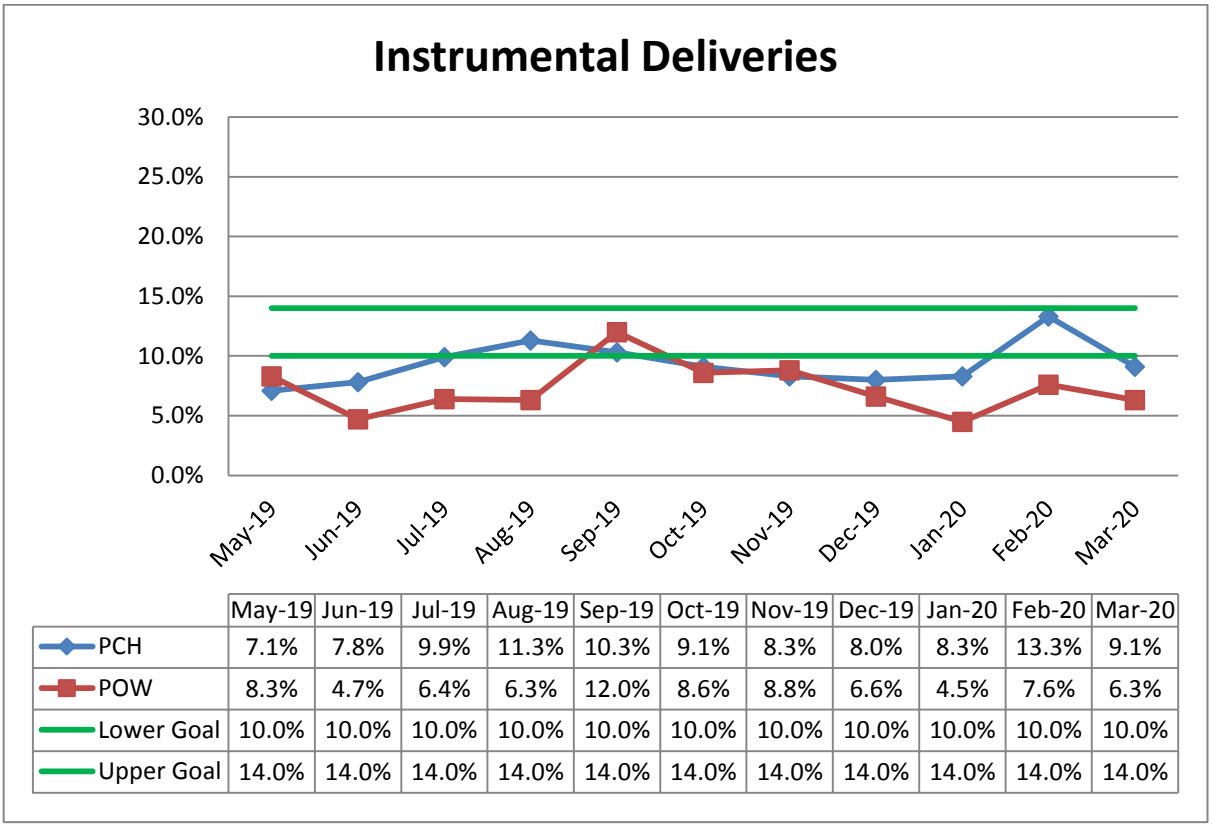
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	53.8%	35.0%	52.4%	31.3%	50.0%	40.0%	52.6%	61.1%	25.0%	61.5%	44.4%	68.4%
POW	33.3%	0.0%	60.0%	71.4%	77.8%	50.0%	50.0%	63.6%	20.0%	83.3%	100.0%	54.5%
Goal	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Instrumental Deliveries

Numerator: Total number of forceps or ventouse births

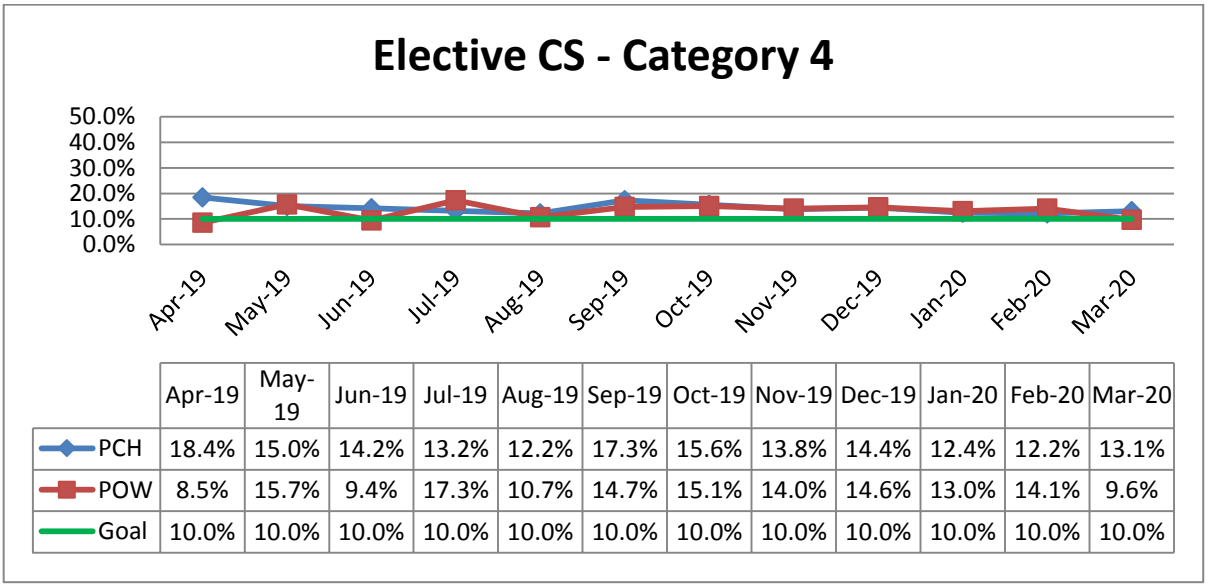
Denominator: Total number of births

Goal: 10.0% - 14.0%



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	7.1%	7.8%	9.9%	11.3%	10.3%	9.1%	8.3%	8.0%	8.3%	13.3%	9.1%
POW	8.3%	4.7%	6.4%	6.3%	12.0%	8.6%	8.8%	6.6%	4.5%	7.6%	6.3%
Lower Goal	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Upper Goal	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%

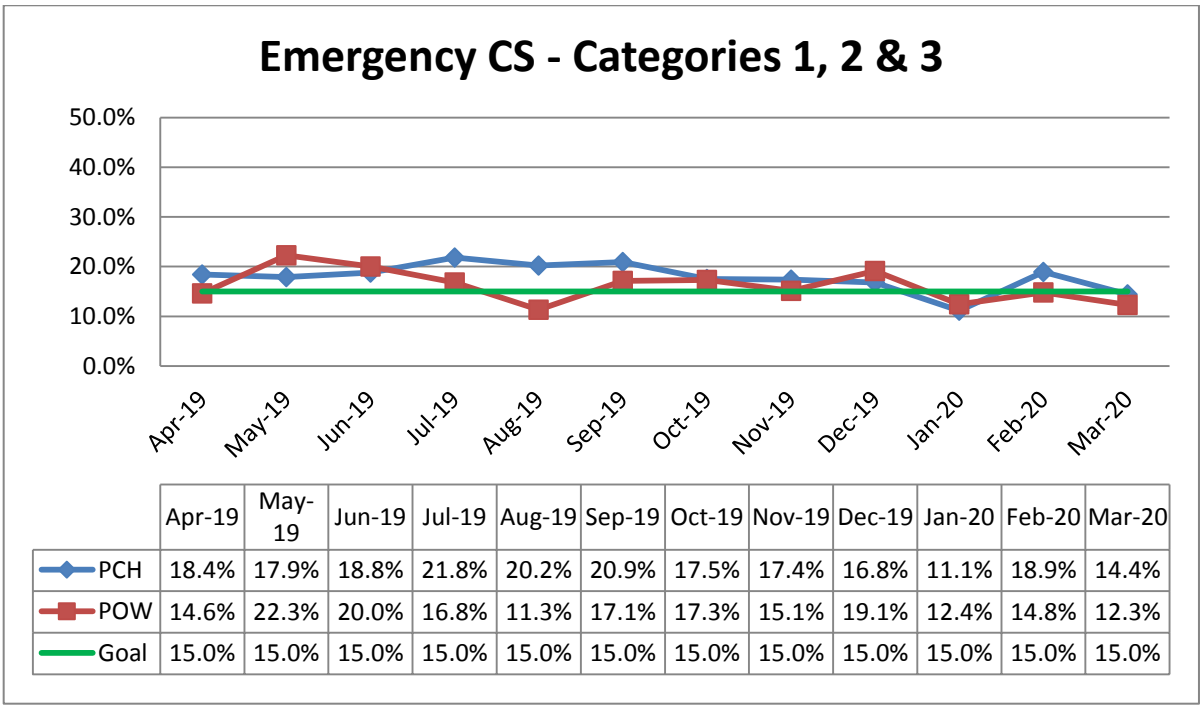
Elective CS – Category 4
Numerator: Total number of women delivering by Category 4
Denominator: Total number of women delivering
Goal: 10.0%
Please note: Previously reported Electives as Category 3 and 4, now reporting as Category 4 only



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	18.4%	15.0%	14.2%	13.2%	12.2%	17.3%	15.6%	13.8%	14.4%	12.4%	12.2%	13.1%
POW	8.5%	15.7%	9.4%	17.3%	10.7%	14.7%	15.1%	14.0%	14.6%	13.0%	14.1%	9.6%
Goal	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%

Emergency CS – Categories 1, 2 & 3

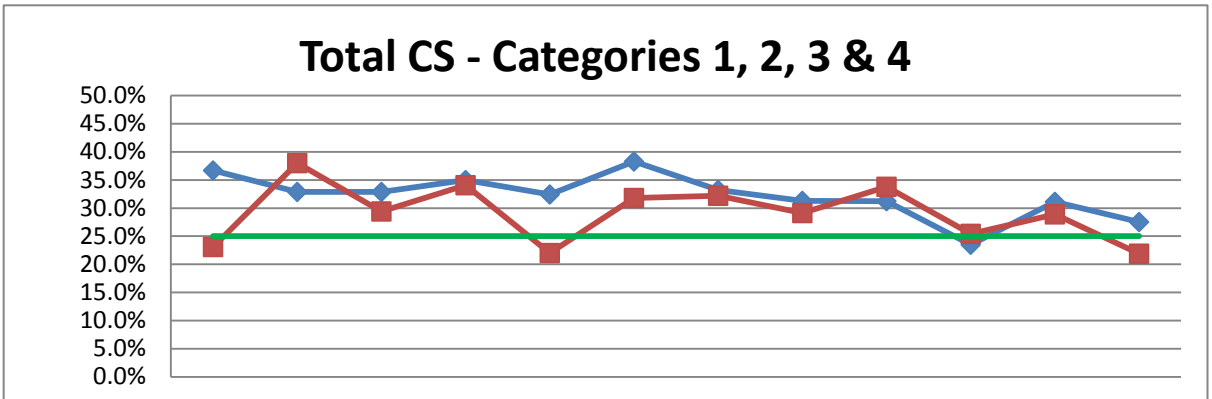
Numerator: Total number of women delivering by Category 1, 2 or 3
Denominator: Total number of women delivering
Goal: 15.0%
Please note: Previously reported Emergencies as Category 1 and 2, now reporting as Categories 1, 2 and 3



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	18.4%	17.9%	18.8%	21.8%	20.2%	20.9%	17.5%	17.4%	16.8%	11.1%	18.9%	14.4%
POW	14.6%	22.3%	20.0%	16.8%	11.3%	17.1%	17.3%	15.1%	19.1%	12.4%	14.8%	12.3%
Goal	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%	15.0%

Total CS

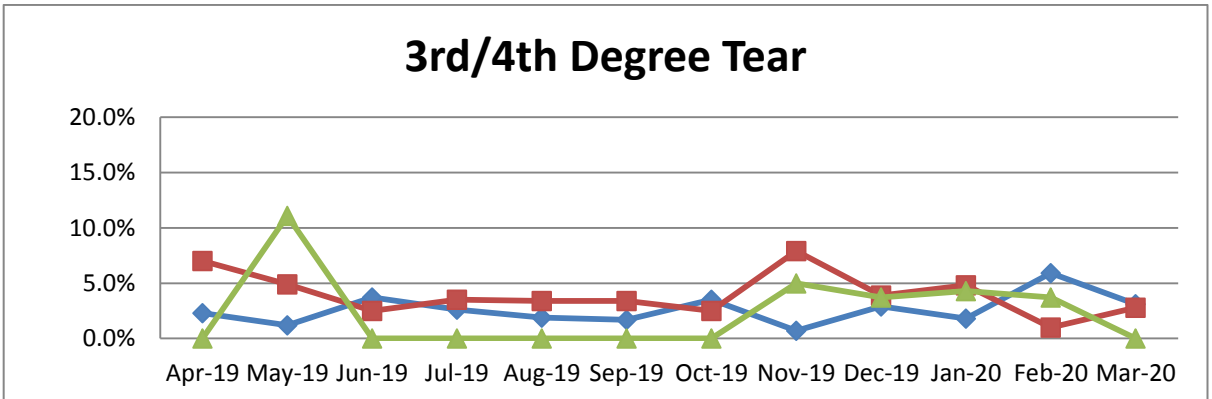
Numerator: Total number of women delivering by any category of CS
Denominator: Total number of women delivering
Goal: 25.0%



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	36.7%	32.9%	32.9%	35.0%	32.4%	38.3%	33.2%	31.3%	31.2%	23.5%	31.1%	27.5%
POW	23.1%	38.0%	29.4%	34.1%	22.0%	31.8%	32.2%	29.1%	33.8%	25.4%	28.9%	21.9%
Goal	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%

3rd/4th Degree Tear

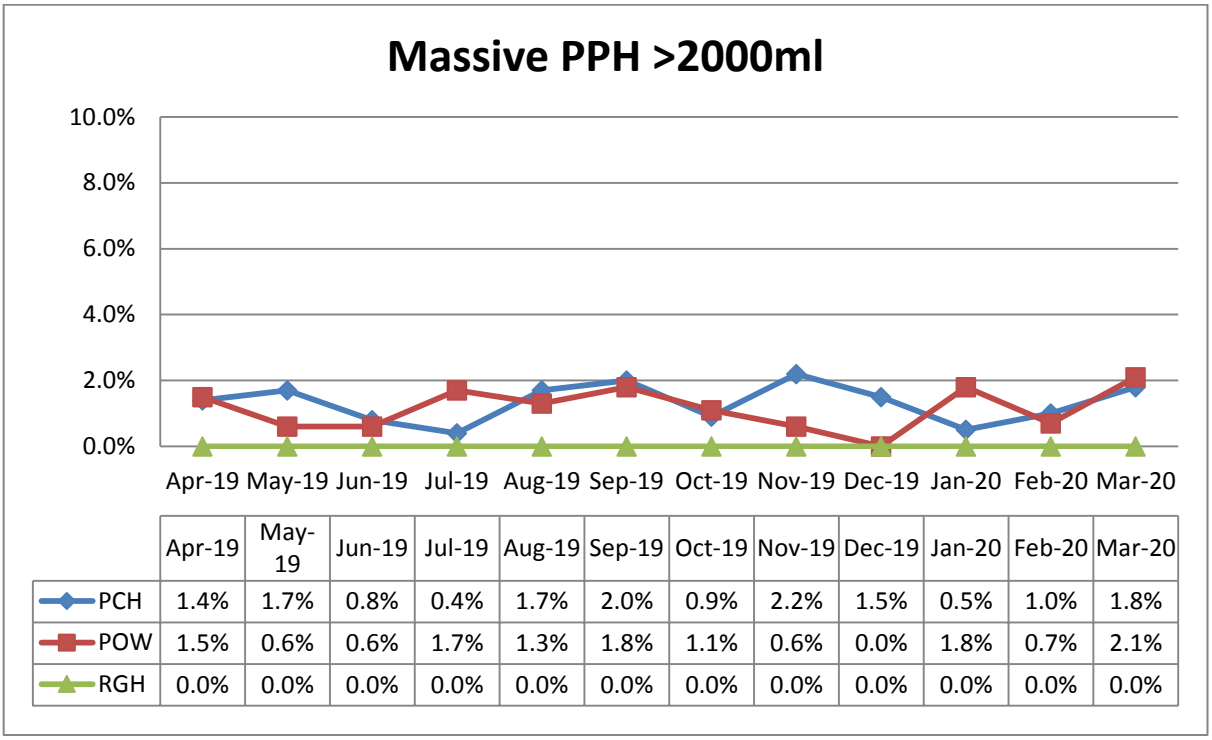
Numerator: Total number of women delivering having a vaginal delivery with 3rd or 4th degree tear
Denominator: Total number of women having a vaginal delivery



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	2.3%	1.2%	3.7%	2.6%	1.9%	1.7%	3.5%	0.7%	2.9%	1.8%	5.9%	3.1%
POW	7.0%	4.9%	2.5%	3.5%	3.4%	3.4%	2.5%	7.9%	3.9%	4.8%	1.0%	2.8%
RGH	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	3.7%	4.3%	3.7%	0.0%

Massive PPH >2L

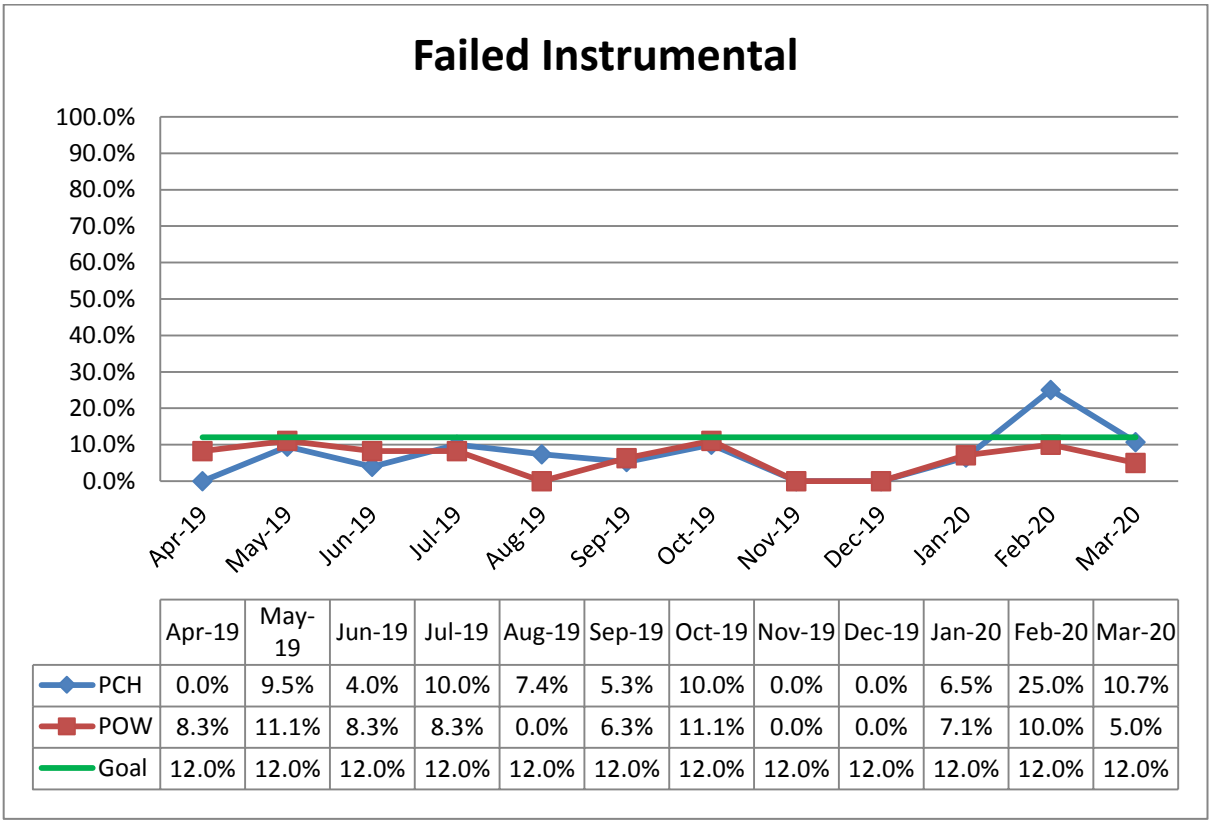
Numerator: Total number of women having an intrapartum blood loss >2000ml
Denominator: Total number of women delivering



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	1.4%	1.7%	0.8%	0.4%	1.7%	2.0%	0.9%	2.2%	1.5%	0.5%	1.0%	1.8%
POW	1.5%	0.6%	0.6%	1.7%	1.3%	1.8%	1.1%	0.6%	0.0%	1.8%	0.7%	2.1%
RGH	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Failed Instrumental

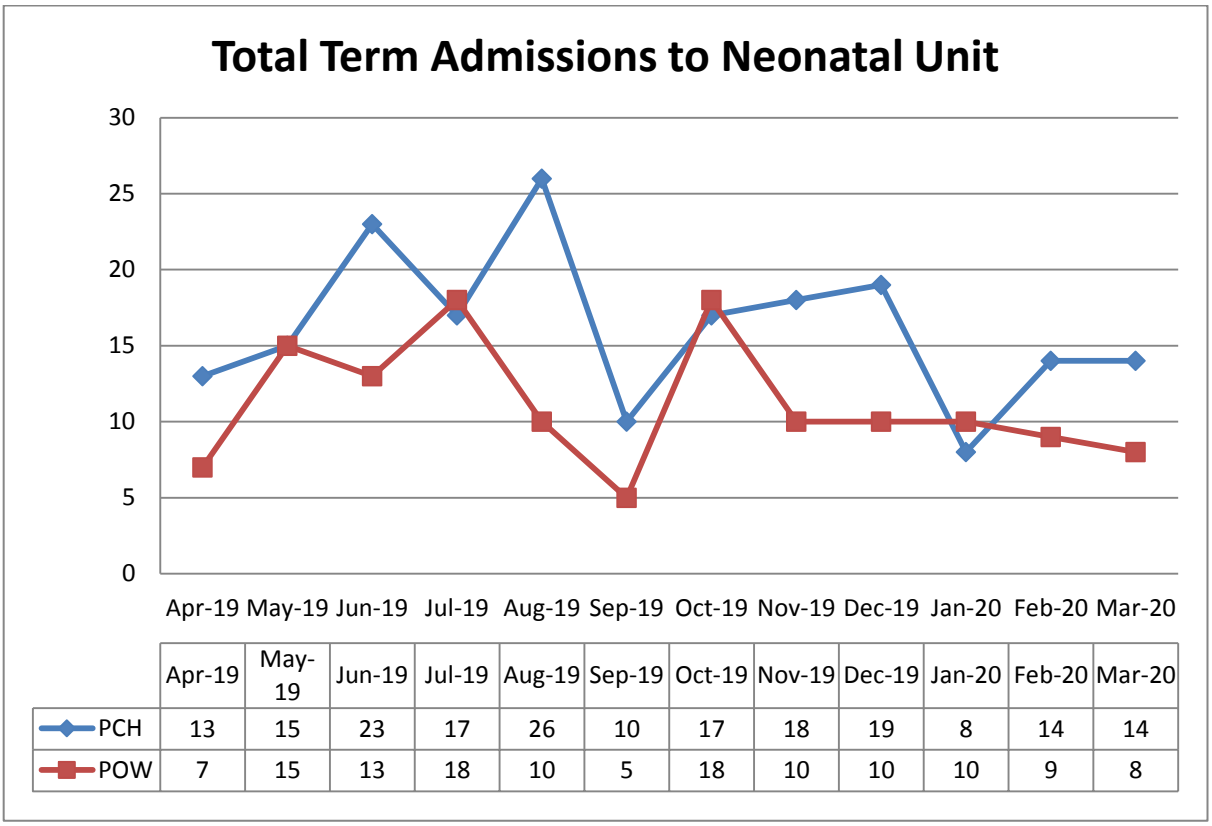
Numerator: Total number of births attempted instrumental delivery and failed
Denominator: Total number of births attempted instrumental delivery
Goal: 12.0%



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	0.0%	9.5%	4.0%	10.0%	7.4%	5.3%	10.0%	0.0%	0.0%	6.5%	25.0%	10.7%
POW	8.3%	11.1%	8.3%	8.3%	0.0%	6.3%	11.1%	0.0%	0.0%	7.1%	10.0%	5.0%
Goal	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%

Term Admissions to Neonatal Unit

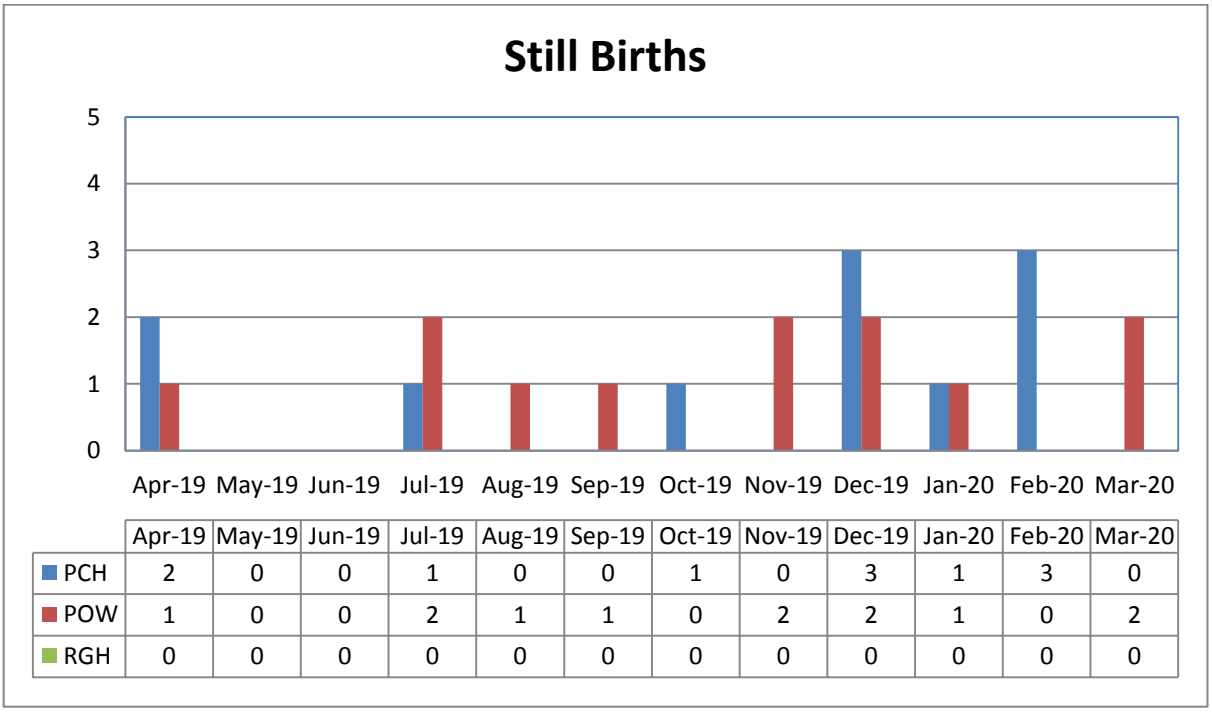
Total number of term (>=37 weeks gestation) babies admitted to Neonatal Unit.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	13	15	23	17	26	10	17	18	19	8	14	14
POW	7	15	13	18	10	5	18	10	10	10	9	8

Stillbirths

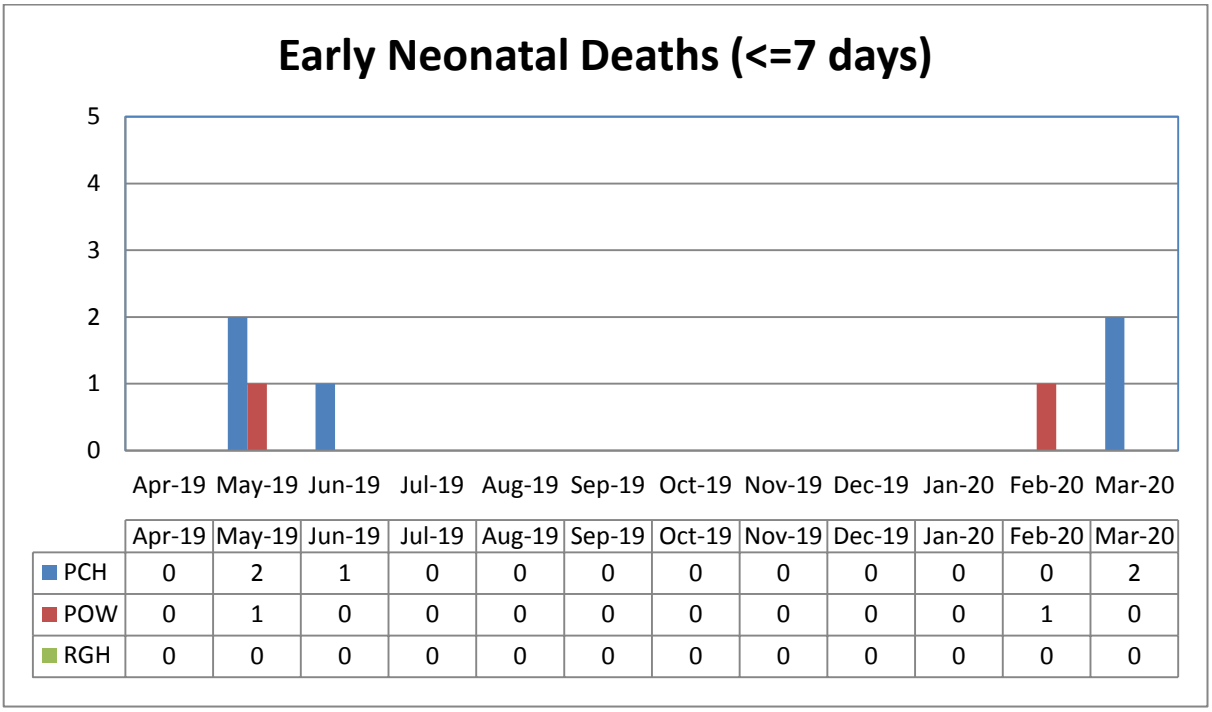
Total number of stillbirths



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	2	0	0	1	0	0	1	0	3	1	3	0
POW	1	0	0	2	1	1	0	2	2	1	0	2
RGH	0	0	0	0	0	0	0	0	0	0	0	0

Early Neonatal Deaths (<=7 days)

Total number of neonatal deaths within 7 days of birth. Counted in the month of death.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
PCH	0	2	1	0	0	0	0	0	0	0	0	2
POW	0	1	0	0	0	0	0	0	0	0	1	0
RGH	0	0	0	0	0	0	0	0	0	0	0	0

Safe & Effective Care - Master Action Plan & Evidence					
RCOG Reference	**Health Board Proposed Status**	**IMSOP validated and approved**	**Status Trajectory / follow-Up**	**Recommendation**	**Current Status Examples of assurance evidence**
7.1	In progress		30/06/20	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	**Evidenced through:** • MITS has been upgraded to incorporate partial Trigger List. •Audit plan for 2019/20 and achievement/progress of the plan • Performance Scorecard devised and in use. • Reporting to National Audits: • MBRRACE • Each Baby Counts Update 17/04/20: Further Evidence for next quarter work identified in feedback from Medical Director/Head of Clinical Audit & Quality Informatics requested 19/02/20 – Head of CA & QI leading on investment in Qlik Sense and coding of data • Evidence of additional coding capacity posts • Evidence of improvements in quality of coding and data entry - through reduction of clinician contact in double checking process
7.2	In progress			Ensure all guidelines are up to date, reviewed and ratified by nominated obstetric lead and senior midwife Any Maternity guidelines developed which contain the administration of medication will require approval by a Pharmacy Lead.	Update 17/04/20: Further Evidence for next quarter Lead midwife identified to look at implementing a consistent and co-ordinated approach to development, approval and monitoring of guidelines All maternity policies which contain administration of medication are approved via the Medicines Ethics committee which meets on a 12 weekly basis Lead Obstetric Consultant is also in the process of establishing a guidelines group Standard reporting process to include monitoring of guidelines and policies to develop 3 year look ahead - to include MD review

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7.7	Slippage		01/03/20	Ensure an environment of privacy and dignity of care for women undergoing abortion or miscarriage in line with agreed national standards of care.	<u>Update 17/04/20: Further Evidence for next quarter</u> Significant work has been undertaken in the form of: • Development of a business case • escalation to the Head of Midwifery/Service Group General Manager • Flagged on the risk register ***No dedicated space on the PCH site****
7.19	In progress		August 2020	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.	**Evidenced Through:** • The SI trigger list is available for senior midwifery staff and the clinical director and labour ward leads. • The senior team all have access to Datix and will review all reported incidents within 24 hours (working days) to determine any requiring further investigation and possible SI reporting. • MDT clinical incident meetings have been established to review incidents and identify any requiring SI reporting • Incidents which staff consider 'serious' are reported to the senior midwifery staff – in and out of hours via the senior midwife on call rota • There are a group of staff requiring RCA training which has been escalated to the corporate patient safety team who are currently sourcing the training. • 03/12/19 Update: Draft SI trigger list from WG. <u>Update 17/04/20: Further Evidence for next quarter</u> Flow charts which clearly outline process for SI's Reporting on themes Establishment of a learning to Improve Group Quarterly Impact Assessments

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7.20	In progress		August 2020	Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from Sis.	**Evidenced Through:** • Governance infrastructure developed to support no blame culture. Learning from SI's, complaints and patient stories now being used more openly at governance days. Staff feedback at PCH is that safety briefings can still feel critical and bruising. • Need to build in work programme that includes how to give and receive feedback <u>Update 17/04/20: Further Evidence for next quarter</u> Update: External agencies providing training to all staff. Plan currently being completed. OD Programme New management team HEIW feedback Datix training Incident reporting increased – need to evidence learning

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7.51	In progress		August 2020	Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety: 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 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.	Women's experience midwife appointed 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. <u>Update 17/04/20: Further Evidence for next quarter</u> Using the Patient Safety Qlik Sense Apps, data is triangulated from SI's, Concerns both formal and informal, Claims, patient safety incidents and also positive feedback captured via PALS service. Data is themed to highlight hot spot areas where targeted improvement work needs to be undertaken and also to identify areas of good practice. Reports are shared with staff within the Directorates

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Delivery Unit Report (Dec 2019) (5)			Covered under 7.19/ 7.23	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. Review the HB methodology for carrying out investigation including the monitoring 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 (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 <u>Update 18/2/20 Checking Visit IMSOP - agreed that this work is already being picked up in 7.19, 7.20, 7.23</u> <u>Update 17/04/20: Further Evidence for next quarter DM discussed with LM further evidence supplied</u> **for sign off in next quarter**

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Delivery Unit Report (Dec 2019) (6)			Covered under 7.19/ 7.23	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, 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 pro**c**esses 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 <u>Update 18/02/20 Checking Visit IMSOP - agreed that this work is already being picked up in 7.19, 7.20, 7.23</u>
Delivery Unit Report (Dec 2019)1a)			Covered under 7.19/ 7.23	Develop a log of the aggregated action plans for monitoring of implementation.	Aggregated learning plan
DU	Partial Completion		Plan of training required	Simplify the current processes for review of an incident and make 'patient safety' the focus of the review (rather than grading for external reporting).	CTG, PROMPT etc.

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Internal action	In progress			Theatre standards in ACT	Weekly Dashboard & Education forum exception report
Internal action	New			Embrace Report	
Internal action	New			Specific plan around neonatal improvements	