User experience and engagement

Quality of Women's Experience

Workstream Lead: Byrony Tweedale & Samantha Lewis

Key		
Late	RCOG Recommendation/Service Improvement Action	IMSOP Assurance RAG/measure TBC
Completed awaiting IMSOP signoff	Action Header	Monthly Assurance Assessment
Concerns	Action Milestone	
On Track	New Action	

What failings led to the recommendation

It was not clear how engagement with women using maternity services will take place, there was clearly a need for meaningful dialogue with the public through the programme of community engagement. This would benefit from an increase in outreach to existing forums and community activity and the development of innovative methods that meet the needs of all communities and women. There was a need to increase the influence of patient experience on quality and safety of maternity and other services. Feedback from women and families regarding failures in the quality and safety of care and poor communication highlighted the need to build an even wider range of appropriate methods and approaches in order to gain insight into patient experience.

The way feedback from patient experience was translated into action was not always clear and the line of accountability to the Board was missing. The monitoring of the outcomes of patient experience is a key part of the governance structure and must be addressed as a priority. The outcomes of all engagement should be fed back to women and families.

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RCOG	Ref	Actions required	Responsible Lead	Start Date	Completion date	Completed?	Date verifed by panel	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
7.47	Ex1	**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: (7.47)**										
7.47	Ex1.1a	Appoint a Lay Chair as a matter of priority and increase lay membership numbers with appropriate support and resource	SF/SL	Closed No Further Action			03/08/2020	Infleuence the strategic direction of the service Hold service to account to demonstrate improvement and relevance to needs of Womens & Families who use the service	Lay chair appointed Providing adequate oversight and support for group Increase in membership by X% Continuos appointment	Agenda TOR Notes of meeting	Y	
7.47	Ex1.1b	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. (cluster with 7.49)	SF/SL						Attendance of MMMW members at engagement events Completion of site visits using '15 steps' by Lay members	Involvement in the development of engagement events and information 15 Steps report	Y	
7.47	Ex1.1c	Enhance the MMMW monitoring role in order to assess whether patterns of concerns are found and to ask for regular feedback on action taken.	SF/SL						Attendance & Active participation from Chair in engagement events Comprehensive production of annual programme & report by Lay Chair Oversight of production of thematic analysis	PALS Feedback Concerns reports Lay Chair's Annual Programme & Report Thematic Analysis document	Y	
7.47	Ex1.1d	To act as a hub for service user views and involvement of women and families to improve maternity care:	SF/SL						Increase in membership Active participation via appropriate mechanisms Annual work plan	Involvement in the development and review of guidliens and engagement events	Y	
	Ex1.2	**Advertising of MMMW to service users and service user representatives on a continuous basis**	SL	03/07/2020	28/08/2020	N			X# individuals reached evry month Completion and distribution of poster	Facebook reach report/evidnce Poster	N	
	Ex1.2a	Establish process to ensure pinned post on social media (Bump Talk) is re-advertised weekly		03/07/2020	28/08/2020	N					N	
	Ex1.2b	Complete poster and distribute to community midwives to carry in leaflet format (staff awareness)		15/06/2020	04/09/2020	Y					Y	
	Ex1.3	**Maintain up to date distribution list of active MMMW members**	SL	21/07/2020	24/07/2020	Y			Contact exsisting members every 6 months	Emails Electronic Disribution list	Y	
	Ex1.3a	Telephone call or email to ensure members still wish to be involved		21/07/2020	24/07/2020	Y					Y	
	Ex1.3b	Establish process to add interested parties to distribution list to receive joining instructions		21/07/2020	24/07/2020	Y					Y	
	Ex1.4	**Retention of individual in MMMW Lay Chair post (maximum 2 yearly new appointment)**	BT/SL	14/07/2020	04/09/2020	N			Lay chair post filled # of months in post for Lay chair	Advert for Lay Chair Opportunity Agenda	N	
	Ex1.4a	Advertise lay chair position to MMMW members		14/07/2020	14/07/2020	N						
	Ex1.4b	Timely interview and recruitment of Lay chair		14/07/2020	04/09/2020	N						
	Ex1.5	**Oversight of annual programme of MMMW activities and targets and the annual reporting of this programme of work**	BT/SL	16/09/2020	28/10/2020	N			Programme calendar & documentation in place	Programme calendar & documentation	N	
	Ex1.5a	Create annual programme with MMMW Lay chair and members		16/09/2020	28/10/2020	N						
	Ex1.5b	Set date for receipt of annual programme report		28/10/2020	28/10/2020	N						
	Ex1.6	**Ensure the maternity service uses feedback from the MMMW forum to develop, respond and triangulate service user feedback**	BT/SL	01/03/2019	30/05/2020	N			Presence of MMMW reporting on monthly assurance meeting agendas	Agenda (including action plans) Notes of meeting TORs Annual Programme & Report	N	
	Ex1.6a	Establish process for each MMMW meeting to include an Action Plan for taking forward actions		30/05/2020	30/05/2020	Y					Y	
	Ex1.6b	Esnure agenda item for MMMW (by exception) to be included on Q&S forum and Labour ward forum		01/06/2020	01/06/2020	Y					Y	
	Ex1.6c	Women and Families forum to be attended by Lay chair from MMMW		21/08/2020	21/08/2020	N					N	
	Ex1.7	**Review TOR for MMMW to ensure these are fit for purpose**	BT/SL	29/07/2020	29/07/2020	Y			Annual Review of TORs		Y	
7.49	Ex2	**Develop the range and scope of engagement with women and families**										
7.49	Ex2.1a	Review the effectiveness of patient experience methodology and its impact on service change and improvement as a result of feedback (cluster with 7.52)	BT/SL/KD	01/03/2019	30/05/2020	Y	12/08/2020	Service user feedback monitoring embeded into governance stucture	Service direction demonstrates priorities identified through engagement work		Y	completed according to plan from 01/06/2020
7.49	Ex.2.1b	As a priority review and address the monitoring of the outcomes of women and families as a key part of governance structure		01/03/2019	30/05/2020	Y		Service direction demonstrates priorities identified through engagement work	Womens experience is presented at multiple governance forums and meetings	Governance Days Agenda Minutes	Y	Subject to Covid
7.49	Ex2.1c	Feedback the outcomes of all engagement to women and families		01/03/2019	30/07/2020	Y			# of active/up to date channels for women & families to receive feedback on outcomes	Thematic analysis You said we did Concerns Womens Experience Boards	Y	
7.49	Ex2.1d	Explore methods to hear directly from women and families about their experience including patient stories, diaries, 'mystery shopper' or observation techniques		01/03/2019	30/05/2020	Y					Y	
7.49	Ex2.1e	6 Month follow up		01/02/2021	01/02/2021	N					N	
	Ex2.2	**Co-design a virtual tour of environments of care**	BT/SL	06/07/2020	11/09/2020	N		Using feedback to implement service improvements which are resposive to the anxieties	Up to date virtual tours available for all acute sites	Virtual tour videos Examples of direct HB responses via socail media	N	
	Ex2.2a	Develop virtual tours of acute sites (PCH/ POW/ Tirion)		06/07/2020	11/09/2020	N						
	Ex2.2b	Establish process to review virtual tours and update as necessary, annually		28/07/2020	11/09/2020	N					N	
	Ex2.3	**Introduce 'Women's Experience' Boards to all areas of HB**	SL /Ward Manager	01/03/2019	30/10/2020	N		Women and families are updated on impact of feedback they have provided and how they can find support or get involved	Increased enagement captured by PREM and PALS feedback	Images of Boards Content featured on boards PREM data PALS feedback	N	
	Ex2.3a	Develop key messages and stats of interest to introduced to PCH first		01/03/2019	01/03/2019	Y					Y	
	Ex2.3b	Introduce boards to POW CDS/Ward 12/POW NNU		27/07/2020	28/08/2020	N					N	
	Ex2.3c	Create boards for ANC areas in PCH/POW/RGH/YCR/YCC		28/08/2020	09/10/2020	N					N	
	Ex2.3d	Establish process for updating and monitoring boards		09/10/2020	30/10/2020	N					N	
	Ex2.4	**Identify 'Womens Experience' champions within the midwifery workforce**	BT/SL	17/07/2020	21/08/2020	N		Increased representation of staff and participation in engagament activites by service users and staff	# of active womens experience champions	Advertising Poster women and Families forum agenda featuring womens experience champions section	N	
	Ex2.4a	Advertise and appoint champions (aim for 6 across CTM)		17/07/2020	07/08/2020	N						
	Ex2.4b	Use champions to increase awareness of OWE across the workforce		21/08/2020	21/08/2020	N						
	Ex2.4c	Champions to feedback on themes and trends from their areas of work at Women and Families forum		21/08/2020	21/08/2020	N						
7.52	Ex3	**Learn from the experience of women and families affected by events (7.52)**										
7.52	Ex3.1a	Respond and work with families in the way they require	SF	01/03/2019	31/12/2020	Y	03/08/2020	Multiple mechanisms available to enable women & families to feedback throughout the care pathway	Multiple measures enable clear themes and trends to be identified and inform service improvement TNA evidence clincians are skilled and competent Example banner	PALS Feedback Social Media Engagement Events Thematic anlayis Informal mechanisms PREMS	Y	
7.52	Ex3.1b	Feed learning into the desigh 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. (cluster with 7.49)	VW	01/03/2019	31/12/2020	Y	03/08/2020				Y	
7.52	Ex3.1c	6 Month follow up		01/02/2021	01/02/2021	N					N	
	Ex3.2	**Development of Maternity PREM - Learn from events**	BT	01/06/2020	TBC	N		A Patient Reported Experience Measure in place, to capture experiences and draw insight to assist service development and improvement	# of responses to CQC questionnaire Clear baselines established	Questionnaire Statistical report Thematic analyis Action plans	N	Proposing text message channel. Awaiting more details on PREM
	Ex3.2a	Identify a validated tool (CQC questionnaire)		01/06/2020	01/06/2020	Y					Y	
	Ex3.2b	Explore methods of distributing PREM to service users		31/07/2020	TBC	N					N	
	Ex3.2c	Ensure feedback from PREM is recorded, collected, analysed and baselines are set sufficiently, to influence service changemoving into the future		TBC	TBC	N					N	
	Ex3.2d	Build PREM feedback into future action plans		TBC	TBC	N			TBC		N	
	Ex3.3	**Ensure all women are informed of how they can raise a concern**	SL	01/11/2020	01/12/2020	N		All staff are aware of various methods available for women to raise concerns	% Training compliance of staff	Training documents Email informing staff on role and function of CHC	N	
	Ex3.3a	Train staff on pathways for managing on the spot/informal concerns		01/11/2020	01/12/2020	N					N	
	Ex3.3b	Inform staff on the role and function of CHC		20/07/2020	20/07/2020	Y					Y	
	Ex3.4	**Hold lunch and learn training sessions by CSFMs/PDMs monthly to aid learning around 'hot topics' identified via themes and trends from incidents, complaints and womens feedback**	RMJ	01/11/2020	01/12/2020	N		Learning from experiences of women and improving care provision accordingly	# of staff attending lunch and learn *Dependant on hot topic*	Attendance Register Lunch & Learn Content/Presentation Patient Story	N	*Speak to Ria about database of lunch and learn attendees
	Ex3.4a	Schedule Lunch & learn sessions and book venue		01/06/2020	01/06/2020	Y					N	
	Ex3.4b	Using all maternity forums, identify hot topics for lunch and learn sessions		01/06/2020	01/06/2020	Y					N	
	Ex3.4c	Evaluate impact of lunch and learn session on outcomes		01/11/2020	01/12/2020	N					N	
	Ex3.5	**Utilise patient stories to learn from women and families affected by events**	BT/SL	07/09/2020	09/10/2020	N		Use specific experiences from women and families to influence service change and improvement	# of patient stories available for use in maternity engagamnt forums	Patient stories Forum/meeting agendas	N	
	Ex3.5a	Identify women and families (including dads) to share face-to-face, written or video 'patient stories' around multiple topics		07/09/2020	09/10/2020	N						
	Ex3.5b	Identify repositry to store patient stories		07/09/2020	09/10/2020	N						
	Ex3.6	**Improve "debriefing" process and ensure quality and consistency across the service**	BT/SL	04/11/2019	TBC	N		Debrief is accessible to all women who request service and is good quality and meaningful	% of women offered a debrief % of women taking up debrief	Feedback of women	N	
	Ex3.6a	Analyse feedback from engagement events and carry out thematic analysis		04/11/2019	27/03/2020	Y					Y	
	Ex3.6b	Scope current provision of "debreifing" services and referal processes offered to women in Maternity Services		20/07/2020	28/08/2020	N					N	
	Ex3.6c	Develop a plan to implement changes required *TBC*		28/08/2020	30/09/2020	N					N	
	Ex3.6d	Implement changes identified *TBC*		TBC	TBC	N					N	
	Ex3.7	**Plan and deliver engagement events focused on early loss**	MD	01/08/2020	31/12/2020	N		Use experiences from women and families to influence service change and improvement	# Early loss engagment events Reduction in # of complaints regarding early loss Womens experience survey	Events resources & attendee list Surveyr & responses Datix concerns report	N	
	Ex3.7a	Plan event, liaise with Gynea and surgical leads		01/08/2020	01/09/2020	N						
	Ex3.7b	Advertise event on social meadia, within hospitals and at venue		01/09/2020	01/10/2020	N						
	Ex3.7c	Deliver the event and collect feedback		01/11/2020	01/11/2020	N						
	Ex3.7d	Analyse feedback and build into action plan going forward		01/11/2020	01/12/2020	N						
	Ex3.7Ex	Build Early Loss engagement events into maternity Engagement plan		01/12/2020	31/12/2020	N						
	Ex3.8	**Provide the opportunity for engagament and feedback for women during the RCA process**	ZA (Replacement)	01/01/2020	31/07/2020	N		All women whos care undergoes RCA investigation recives opportunity to contribute to process & will receive individualised feedback	100% of women who require RCA are offered the opportunity to engage during this process	Themes and trends, complaints and concerns reports and riskwise newsletter shared with MMMW group RCA process and reports	N	
7.53	Ex4	**Review the communications, support and engagement approach and strategy**										
7.53	Ex4.1a	Ensure that the focus is not soley on management of key messages	SF	01/04/2020	01/09/2020	N		Sustained focus on co-production and receiving a range of feedback from Women and Families	Reciprocal communication between maternity services and service users and the community	MMMW agendas, TORs & minutes Action Plans Women's Experience Boards CTM Babies PREMs PALS Feedback	N	
7.53	Ex4.1b	Demonstrate openness, honesty and transparency, admission of fault and learning from this		01/04/2020	01/09/2020	N		All service users feel that we are open, honest and transparent around management of incidents	Service user feedback (PREM) TBC	PREMS Service User Feedback PALS Concerns	N	
	Ex4.2	**Explore new/current channels of communication/engagement with women & Families**	SL	01/04/2020	28/08/2020	N		All women whos care undergoes RCA investigation	100% of women who require RCA are offered	Themes and trends, complaints and concerns reports and	N	
	Ex4.2a	Provide the opportunity for engagament and feedback for women during the RCA process		01/01/2020	31/07/2020	N						
	Ex4.3	**Explore new ways of encouraging conversation between staff and families**	BT/SL/KG	01/06/2020	31/08/2020	N		Reinforces appropriate introduction and communications	Use of badges and lanyards on wards and within the community Changes/Improvements	Staff and service user feedback	N	Waiting to recive badges
	Ex4.3a	Explore the use of 'My name is…….' Staff badges/lanyards & Explore the use of 'Ask me about…' / 'Talk to me about……' Badges for staff		01/06/2020	31/08/2020	N						
	Ex4.3b	Inform staff on the purpose and use of badges		31/08/2020	30/09/2020	N						
	Ex4.4	**Develop #CTM Babies monthly stats board of key data of babies born within CTM 7.53**	BT/SL	17/07/2020	07/09/2020	N		Positive events shared with women and families and increased engagement with our communities	# of CTM babies posts on "Bump Talk" Facebook page	Visual template Social Media Posts	N	
	Ex4.4a	Liaise with medical illustrations to create a visual template which will be updated monthly		17/07/2020	07/09/2020	N						
	Ex4.4b	Secure social media access for WEM to update social media site with CTM Babies board on a monthly basis		07/09/2020	07/09/2020	N						
	Ex4.5	**Create ANC video to be displayed in ANC areas across CTM 7.53**	SL	01/12/2020	01/01/2021	N		Improving messaging range of communication methods with women and families	# of active/up to date channels for women & families to engage with Maternity Services	Video	N	
7.54	Ex5	**Prioritise an engagement programme with families at its heart. (7.54)**										
7.54	Ex5.1a	Women and families affected by events should be part of the improvement, co-design and culture change of the new service,	BT/SL	01/03/2019	30/05/2020	N		Services are tailored to fit the needs of the communities we serve. We capture the experiences of women and families using the service to co-produce on service development and improvement	Increase in # of members of MMMW who have been affected byu events	MMMW minutes/distribution list CTM Co-produceed MAT vision 15 steps challenge Social Media post Women & Families agenda/minutes	N	
	Ex5.2	**Engagement in matetnity alligns itself to the organisational visions and values**	SF	01/03/2020	01/01/2021	N		Clear and consistent aims run through the organisation	Alignement of Plans	The service 5 year plan will be agreed and publicised Women and families will understand the vision of the materntiy service	N	Waiting on CTM Corporate visions and values
	Ex5.3	**Develop an annual women and families engagement programme**	BT/SL	01/03/2020	18/09/2020	N		Services are tailored to fit the needs of the communities we serve. Capture the experiences of women and families using the service to co-produce on service development and improvement	Set baselines for attendance numbers % change in attendance	Event advertising Venue documentation Attendance Register	N	
	Ex5.3a	Finalise and embed Maternity Engagement Plan 2020-2023'		01/03/2020	18/09/2020	N						
	Ex5.3b	Identify aims, dates & venues for engagement activities		01/07/2020	28/08/2020	N						subject to changes due to Covid-19
	Ex5.3c	Establish minimum social media calendar of engagement/communications with varied content		27/07/2020	07/09/2020	N			Set baselines and increase # 'reached' every month # of posts every month # of new members joining maternity social media page every month	Social media posts Social media stats reports Examples of direct HB responses via socail media		(propose minimum 3 per weekly posts – including links to relevant organisations e.g. International Day of the Midwife, Breastfeeding Week, White ribbon day, GBS awareness month…..)
	Ex5.3d	Advertise CTM Maternity social media forum for women to join		03/08/2020	07/09/2020							
	Ex5.3Ex	Determine approach to analysis of social media reach and how to improve engagement via this channel		27/07/2020	18/09/2020	N						
	Ex5.4	**Staff within the service will proactively engage**	BT	29/05/2020	30/11/2020	N		Staff morale improves, they feel valued by the organisation. Staff are up to date on current news and	% improvement in staff survey results	Unit meetings quarterly Meetings for all bands available	N	
	Ex5.4a	Develop an annual staff engagement programme		20/09/2020	20/11/2020	N						
	Ex5.4b	Embed staff engagement in unit meetings and other work forums into standard practice		29/05/2020	21/11/2020	N					N	
	Ex5.4c	Establish Senior team breifing and Q&A session for all maternity staff		01/09/2020	22/11/2020	N					N	
	Ex5.5	**Offer all women the opportunity to feedback**	BT	01/03/2020	30/11/2020	N		Women and families feel their experience valued and fundamental to service development and improvement	Multiple methodologies will be available and communicated throughout the materntiy journey	Methodologies summarised in booking documentation Feedback site on social media set up explaining methodologies and how to access them Midwife engagement champions	N	Duplicate, decide where it goes best
	Ex5.6	**The materntiy service shows improvement based on women and families feedback**	BT	Date of Maturity Matrix	30/11/2020	N		Reduction in concerns and complaints, more compliments received	Quarterly Experience Forum meeting to triangulate feedback	Quarterly "you said we did" posters across the services Social media to summarise posters	N	
7.67	Ex6	**Develop a strategic vision for the maternity service and use the current opportunity of change to create a modern service which is responsive to the women and their families and the staff who provide care**	BT/SL	01/12/2020	01/01/2021	N		Women and families feel their experience valued and fundamental to service development and improvement	Monthly Women and Famiies forum meeting to triangulate feedback. MMMW to triangulate feedback. Increased women's enagement and co-production	CTM Maternity Vision document, Minutes rom co-prodcution meeting regarding the Maternity vision document, Women and Families forum minutes/agendas, Maternity Engagement plan	N	
7.70	Ex7	**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.**										
7.70	Ex7.1a	Ensure the service is adequately staffed to ensure that all staff groups are able to participate in developing the vision	VW	01/06/2020	31/12/2020	Y		Fully staffed and engaged workforce suppotig the development iof the workforce	Biirthrate plus compliance Coplliant6 stff rotas	birthrate plus compliuance mat services dashboard m onthly workfiorce reporting	Y	Partially complete
7.70	Ex7.1b	Consider an externally facilitated and supported process for review.		TBC	TBC	N					N	
7.70	Ex7.1c	Consider seeking continued support from HIW and the Royal Colleges to undertake a diagnostic review of the service particularly in relation to changes in service provisions.		01/01/2020	TBC	N					N	
7.43	Ex8	**Undertake in-depth assessment of service as it moves into the future - consultation and engagement with staff (moved from mat visions 7.43)**										
7.43	Ex8.1a	This can determine the structures and competencies of clinical leadership and governance that will support the service	SF/SL	Closed No Further Action		Y	18/02/2020	Engagement plan will encompass consultation with staff and service users	Staff engagement	Staff and service user engagment plan	Y	**Check which reccomendation this comes under and if QLM?**
	Ex8.1b	Evaluate exisiting staff engagement processes				Y					Y	

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	Ex9.1c	Develop staff engagement plan				Y				Y	
	Ex9.1a	Develop and implement a Maternity Asso									
	Ex9.1b	Explore ostential and scope for CTM Maternity Asso	TBC	TBC	TBC	N				N	
	Ex10	Scope current breast feedine information, education and support									
	Ex10.1b	Explore current breastfeeding resources in use in CTM		01/08/2020	01/10/2020	N				N	
	Ex10.1c	Audit of women's exxeriences of infant feedine support		01/08/2020	01/10/2020	N				N	
	Ex10.1d	Benchmark breast feedine services against those provided in other services	BT	01/08/2020	01/10/2020	N				N	
	Ex10.1e	Identify community organisations/resources to support provision of breast feeding support		01/08/2020	01/10/2020	N				N	
	Ex10.1f	Alien to baby friendly audit inxention 21 around women's exxeriences		01/08/2020	01/10/2020	N				N	
	Ex11	Scope current provision De-briefine for women and partners									
	Ex11.1a	Explore current de-briefing opportunities and services currently available in CTM		01/07/2020	23/09/2020	N				N	
	Ex11.1b	Explore the rxxentive of de-brief to institutions who use the service		01/07/2020	23/09/2020	N				N	
	Ex11.1c	Identify partner agencies/organisations/resources who provide support for women post-birth		01/07/2020	23/09/2020	N	Use the experience and feedback of women to influence service change and improvement			N	
	Ex11.1d	Develop de-brief pathway for provision of a varying level of de-brief	BT	01/07/2020	23/09/2020	N		TBC	TBC	N	
	Ex11.1e	Identify community organisations/resources to support provision of breast feeding support		01/07/2020	23/09/2020	N				N	
	Ex11.1f	Identify a 'Task & Finish group' with relevant stakeholders to explore the provision of de-brief services		01/07/2020	23/09/2020	N	Ensure all women are offered a de-brief which meets their needs			N	
	Ex12	Scope the current Perinatal Mental Health Service									
	Ex12.1a	Explore current provision of PNMH services available in CTM	BT	01/09/2020	01/11/2020	N	Use the experience and feedback of women to influence service change and improvement	TBC	TBC	N	
	Ex12.1b	Explore the range of MH interventions that the service currently provides Hows not provide		01/09/2020	01/11/2020	N				N	
	Ex12.1c	Identify current PNMH pathways and risk assessments in use		01/09/2020	01/11/2020	N				N	
	Ex13	Screw current inclusive and sensitive Re Pathwa within maternity services in CTM									
	Ex13.1a	Explore current services/resources available for partners within the maternity service.	BT	01/08/2020	30/10/2020	N	Use the experience and feedback of women to influence service change and improvement	TBC	TBC	N	
	Ex13.1b	Conduct an audit of women and their partners to identify how the service can facilitate partner's inclusion		01/08/2020	30/10/2020	N				N	
	Ex13.1c	Jaise with MMMW aroup for service user input.		01/08/2020	30/10/2020	N				N	

Workforce					
Quality of Leadership & Management Workstream Lead: Tarek Allouni	Late	RCOG Recommendation/Service Improvement Action		IMSOP Assurance RAG/measure TBC	Monthly Assurance Assessment
	Completed awaiting IMSOP signoff	Action Header			
	Concerns	Action Milestone			
	On Track	New Action			
What failings led to the recommendations	**Workstream Expected Outcome - Improved staff well-being. A well-Led service**				

Leadership

The assessors found a service working under extreme pressure and under sub-optimal clinical and managerial leadership. The assessors found little evidence that the maternity services are well led or that the culture supports learning and improvement. There are significant issues relating to the staffing of the maternity units within all professional groups at all levels. Many of these have a long and deeply embedded history and are compounded by a lack of engagement with and lack of faith in the management structures. No-one in clinical leadership roles described having received any training in leadership or management skills. There was no line of visible accountability between the maternity service and the Health Board. The assessors concluded that this was a dysfunctional maternity service with many deficiencies in the way it was delivered.

Medical Staff

Lack of agreement about senior medical staff cover (There was no clarity as to how the rota system worked, cover for holidays or absence or what was expected from the consultants e.g. when they were expected to be present on labour ward or when they should attend out of hours), The service reported a high use of locum medical staff at all grades, with locums employed at the RGH site to cover reduced on-call commitments of 3 of the 6 consultants due to sickness. Training grade locums were a regular feature of both sites. There was no evidence of a standard list of situations for which the consultant obstetrician, anaesthetist or paediatrician would be expected to attend. This is essential in a service that is reliant on locum and non- training grade staff. There is a perception that the specialty and associate specialist (SAS) group of doctors who have worked at the Health Board for a long time do not need consultant help, which has resulted in their failure to recognise when a situation is deteriorating in order to call for help in a timely manner. There was no apparent requirement for the outcomes and learning from SI investigations that consultants had been involved in to be included in a consultant's annual appraisal data file. The assessors were told that the job planning system did not meet the needs of this maternity service and could not reflect its complexities. None of the consultants have a signed off job plan that the assessors could view.

Midwifery Staff

The size of the shortfall from establishment of midwifery staff was difficult to quantify accurately. The assessors were informed that midwives currently in a substantive post within the Health Board are also covering bank shifts. This sometimes involves midwives working many hours over their contracted 37.5 hours per week to ensure safe staffing levels. However, this increases the risk of potentially unsafe practice and burnout amongst the midwives. From interviews with senior midwives (8a and above) it is apparent that they are not functioning as a cohesive team. This may have resulted in undermining behaviours between midwives and senior midwives, a lack of a unified approach to service delivery and improvement at a senior midwifery level, as well as inappropriate methods of communication and management both at maternity unit ward level and the resulting corporate response to staff engagement.

MDT working

There was no evidence of a systematic multidisciplinary approach to patient safety or of this being a concern which was ever discussed. During interviews and in group sessions the assessors were repeatedly and consistently told by staff of a reluctance to report patient safety issues because of a fear of blame, suspension or disciplinary action. This was said to be a longstanding issue. Concerns about a punitive culture, lack of recognition of patient safety incidents and escalation is a constant feature with under-reporting and investigation of incidents, but it is also reflective of ineffective multi-disciplinary team (MDT) working.

Training and Education

The lack of compliance with core, mandatory training was a particular concern.

RCOG	Ref	Actions required	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	Date verified by Panel	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
7.8	**W1**	**Ensure external expert faciliation to allow a full review of working practices to ensure: (7.8)**										
7.8	**W1.1**	**patient safety is considered at all stages of service delivery**	VW	01/03/2019	30/12/2020	N		Patient centred and focussed service. Reduction in avoidable harm. Improved patient experience and reduced complaints and concerns.	Weekly Dashboard/ Governance day learning outputs	Suggest SEC 7.19 Case reviews Minutes/Agenda/Governance Days - learning events/case presentation	Y	
7.8	**W1.2**	**a full review of roles and responsibilities within the obstetric team**	JH	01/03/2019	30/12/2020	Y		Effective consultant workforce underpinned by robust job planning leading to improved clinical outcomes ad patient	100% job Plans completed compliant rota	Rota fill x 3 months 100% completed job plans Evidence of % PDR Evidence of % revalidation	N	Neonates appoined external advisor (Dr Chakraborty) to support improvement work
	W1.2a	undertake review of current position to identify gaps with support from external facilitator		01/03/2019	30/12/2020	Y						
	W1.2b	appoint to clinical lead post		01/03/2019	30/12/2020	Y						
	W1.2c	undertake job planning		01/03/2019	31/01/2021	N						
7.8	**W1.3**	**the develop and implementation of guidelines**		01/03/2019	01/10/2020	N		Use of both national and local guidelines that are evidenced based to support patient care. Appropriate incident escalation with a reduction in incidents and avoidable harm Consistency of care	Approved in date guidelines % Forward plan to maintain guidelines and compliancy dates Incidents	Guideline compliancy Plan from guideline group	N	
7.8	**W1.4**	**an approriately trainined and supported system for clinical leadership**	TA	01/03/2019	30/12/2020	Y		Trained and supportive ledership teams at all levels	Improving feedback from staff survey (% improvement to be agreed)	Content of external training package Attendnace monitoring Individual feedback Service action plan content of organisation	Y	The external leadership programme is currently suspended due to Covid 19 restrictions. This will be re-started at the earliest opportunity
	W1.4a	Idenify external leadership training		01/03/2019	30/12/2020	Y						
	W1.4b	identify target groups		01/03/2019	30/12/2020	Y						
	W1.4c	assess individual feedback following completion of programme		01/03/2019	30/12/2020	N						
	W1.4d	Develop service leadership action plan from course output		01/03/2019	30/12/2020	N						
	W1.4e	Develop service plan for on-going leadership development (aligned to corporate provision)		01/03/2019	30/12/2020	N						
7.8	**W1.5**	**a long term plan and strategy for the service**	TA/JH/VW	01/03/2019	31/02/2021			Provision of high quality, women and family centrered maternity services	Agreed vision with staff and women & families	Feedback from staff Feedback from women and families Compliant staffing ratios	N	
	W1.5a	Maternity engagement - designing the future service (align to experience and engagement)		01/07/2020	31/02/2021	N						
	W1.5b	Plan and implement user engagement events to discover womens and families views on the future service		01/07/2020	31/03/2021	N						
	W1.5c	Plan and implement staff engagement events to discover views on the future service		01/08/2020	31/03/2021	N						
	W1.5d	based on feedback review maternity vision (local and All Wales)		31/11/2020	31/03/2021	N						
	W1.5e	Publish Local vision to support delivery of the All Wales Maternity Vision		01/03/2019	31/03/2021	N						
	W1.5f	Develop comphrehensive service plan to align to the future service including *workforce requirement *physical environment review *staff training/development requirement *resource implications		01/03/2019	31/03/2021	N						
7.8	**W1.6**	**there is a programme of cultural development to allow true multi-diciplinary working**	MHT	01/07/2020	31/02/2021	N		Provision of high quality, women and family centrered maternity services	Corporate Values & behaviours work programme	Handovers Governance Days IMTP,evidence of collaboration, MDT working	N	
	W1.6a	Plan and implement user engagement events to discover womens and families views on the future service		01/07/2020	30/09/2020	N						
	W1.6b	Plan and implement staff engagement events to discover views on the future service		01/08/2020	31/03/2021	N						
	W1.6c	based on feedback review maternity vision (local and All Wales)		31/11/2020	31/03/2021	N						
	W1.6d	Publish Local vision to support delivery of the All Wales Maternity Vision		01/03/2019	31/03/2021	N						
	W1.6e	Develop comphrehensive service plan to align to the future service including *workforce requirement *physical environment review *staff training/development requirement *resource implications		01/03/2019	31/03/2021	N						
7.15	**W2**	**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:**										

7.15	W2.1a	junior doctor induction	KM/VW/ Educationl Lead	01/01/2020	30/06/2020	Y	12/08//2020	Clear and consistant approach to underpin incident management in the local areas	Junior docotor induction feedback Attendance register HEIW Visits	Junior Doctor, Locum staff and Midwifery induction programmes Weekly dashboard	Y	
7.15	W2.1b	locum staff induction		01/01/2020	30/06/2020	Y	12/08//2020					
7.15	W2.1c	midwifery staff induction		01/01/2020	30/06/2020	Y	12/08//2020					
7.15	W2.1d	annual mandatory training.		01/01/2020	30/06/2020	Y	12/08//2020					
7.15	W2.1e	6 Month follow up	TA	01/02/2021	01/02/2021	N					N	
7.17	**W3**	**Ensure training is provided for all SAS staff to ensure they are: (7.17)**										
7.17	W3.1a	up to date with clinical competencies	TA/ Educational Lead	01/03/2019	30/09/2020	N		Competent and skilled staff	100% PDR rate Job planning	Flagged as no guidelines across Wales and limited access to PDR's	N	DM to dicsuss issue with PDR with IMSOP Panel
7.17	W3.1b	skilled in covering high risk antenatal clinics and out-patient sessions		01/03/2019	30/09/2020	N						
7.17	W3.1c	Benchmark across Wales		01/06/2020	30/09/2020	N						
7.18	**W4**	**Agree cohesive methods of consultant working after the merger with input from anaesthetic and paediatric colleagues**										
7.18	W4.1a	Evidence of input from anaesthetic and paediatric colleagues	TA/JH/VW	01/03/2019	31/05/2020	Y	03/08/2020	Clear evidence of MDT approach across service	MDT working embedded	Governance days - Minutes/Agenda/Presentations	Y	
7.18	W4.2a	December follow up	TA	01/12/2020	01/12/2020	N					N	
7.22	**W5**	**Actively discuss the outcomes of SIs in which individual consultants were involved in their appraisal**	**RW/ZA**			Y	**12/08/2020**					
7.22	W5.1a	Seek advice from BMA Colleagues	RW/ZA	30/05/2020	30/09/2020	Y	12/08/2020	Learning embeded into service to prevent repetition of incidents Continuous learning and dvelopment within the service from incidents	Review of system undertaken with automatic feedback generated to the individual. Jo meets to discuss learning and outcomes. Cannot access appraisals	Datix Report	Y	
7.22	W5.1b	Reviews of datix system with outcome to be shared with the individual		01/03/2019	31/11/2020	Y	12/08/2020					
7.22	W5.2a	December follow up		01/12/2020	01/12/2020	N					N	
7.29	**W6**	**Closely monitor bank hours undertaken by midwives employed by Cwm Taf, to enure: (7.29)**										
7.29	W6.1a	total number of hours is not excessive	KM/VW/TA/ Educational Lead	Closed No Further Action			03/08/2020	Mainitning adequate staffing levels resulting in delivery of consistent quality of clinical care	Triggers on Eroster Weekly monitoring Dashbaord	Weekly Dashboard	Y	
7.29	W6.1b	the Health board complies with the Europaen Working Time Directive										
7.29	W6.1c	these do not compromise safety										
7.30	**W7**	**Ensure the Medical Director has effective oversight and management of the consultant body by: (7.30)**										
7.30	W7.1a	making sure they are available able and responsive to the needs of the service	TA/VW/JH	Closed No Further Action			03/08/2020	Robust job planning to ensure the team are responsive to the needs of the service	New job plans	Datix trigger highlight issues regrding responsiveness	Y	
7.30	W7.1b	urgently reviewing and agreeing job plans to ensure the service needs are met							Increase labour ward consultant cover to 6hour sper week	Discussions at handover Job planning		
7.30	W7.1c	clarify what is covered as part of SPA activity (audit, governance, teaching, guidelines, data assurance, train more consultant obstetricians as appraisers)	KG						Job planning	Job planning		
7.30	W7.1d	ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hour NCEPOD recommentation (national standard)	KG						QA of handover process	Adequate gynae on-call cover senior reg posts Discussions at handover		
7.32	**W8**	**Ensure obstetric consultant cover is achieved in all clinical areas when required by: (7.32)**										
7.32	W8.1a	reviewing the clinical timetables to ensure that 12 hour cover per day on labour ward is achieved	JH	Closed No Further Action			12/08/2020	Mainitning adequate staffing levels resulting in delivery of consistent quality of clinical care	New job plans undertaken for new model Increaing labour ward consultant cover to 60 hours per week	Visits to units Job plan New model with 12 hour consultant cover - looking at extending this to 9pm	Y	
7.32	W8.1b	undertake a series of visits to units where extended consultant labour ward presence has been implemented	NL									
7.32	W8.1c	considering working in teams to ensure a senior members of the team is available in clinics and provide cross cover for each	TA/JH/VW									
7.32	W8.1d	considering the creative use of consultant time in regular hours and out of hours to limit the use of locums	TA/JH/VW									
7.34	**W9**	**Allocate all trainees currently in post a clinical and educational supervisor (7.34)**										
7.34	W9.1a	The role of clinical supervisor and educational supervisor should be documented and closely monitored by the Director of Medical Education	**TA**	01/05/2019	30/05/2020	Y	12/08/2020	Supportive culture for all trainess	Attendance rate	Deanery action plan Trainee hand booklet Trainee induction pack	Y	This has been in place over the past 12 months
7.34	W9.1b	The competency assessments for trainees must be provided in-house under the supervision of the RCOG College Tutor		01/05/2019	30/05/2020	Y	12/08/2020					
7.34	W9.2a	December follow up		01/12/2020	01/12/2020	N					N	
7.35	**W10**	**Undertake a training needs assessment for all staff to identify skills gaps and target additional training (7.35)**	TA/JH/VW	01/03/2019	28/02/2021	N		All staff are trainined appropriately	PDR Job planning Appraisal PROMPT	PDR Job planning Appraisal PROMPT	N	
7.37	**W11**	**Develop an effective department wide multi-disciplinary teaching programme (7.37)**										

7.37	W11.1a	This must be adequately resourced and time allocated for attendance by all staff groups including specialist clinical midwives and SAS doctors.	TA/JH/VW	Closed No Further Action			03/08/2020	All staff are trainined appropriately	Governance Day Attendance on training programmes	PROMPT CTG Training development Forum Weekly teaching Induction packs	Y	
7.37	W11.1b	attendance must be monitored and reviewed at appraisal						Opportunity to asses current performance and future development needs				
7.39	**W12**	**Review the working practice for how consultant cover for gynaecology services will be delivered after the merger. (7.39)**										
7.39	W12.1a	A risk assessment must be performend to determine the case mix of planned surgery on the Royal Glamorgan site when there is no resident gynaecology cover.	DC/ PD	01/03/2013	31/11/2020	N		Gynaecology services remain at RGH site Process for patients between the 2 gynaecology services Safe service for local provision of services for patients		Gynae and Obstetric separate consultant on call rotas. Risk assessments for service moves	N	
7.42	**W13**	**In conjunction with Organisational Development undertake work with all grades of staff around communication, mutual respect and professional behaviours. (7.42, 7.56)**										
7.42	W13.1a	Staff must be held to account for poor behaviours and understand how this impacts on women's safety and outcomes	KM/VW/Education al Lead /RP	01/03/2019	31/03/2021	N		Supportive culture and environment for all staff and service users	Health Boards Values work	Rothy Park Sessions Mandatory Training HB Values work Dignity at work trianing	N	
7.44	**W14**	**Support training in clinical leadership (7.44)**										
7.44	W14.1a	The Health Board must allow adequate time and support for clinical leadership to function	KM/VW/RP Educational Lead	01/03/2019	30/06/2020	Y		Providing a support environment for senior clinical leads	Total number of job plans completed Role description	Allocated sessions within Job Plans Dedicated support to the clinical director Increased number of sessions Coaching sessions	Y	
7.45	**W16**	**Provide mentorship and support to the clinical director (7.45)**										
7.45	W16.1a	Define the responsibilities of this role	MHT/RA	01/03/2019	01/01/2020	Y		Providing a support environment for senior clinical leads	Total number of job plans completed	Allocated sessions within Job Plans	Y	
7.45	W16.1b	Ensure there are measurable performance indicators		01/03/2019	01/01/2020	Y						
7.45	W16.1c	Ensure informed HR advice to consistently manage colleagues' absence and deployment of staff to cover the needs of the service		01/03/2019	01/01/2020	Y						
7.45	W16.1d	Consider buddying with a Clinical Director from a neighbouring Health Board		01/03/2019	01/01/2020	Y						
7.56	**W17**	**Provide communication skills for staff, in particular on empathy, compassion and kindness (7.56, also aligns to 7.42)**										
7.56	W17.1a	empathy, compassion and kindness	TA/RW	01/03/2019	01/02/2021	N		Supportive culture and environment for all staff and service users	Health Boards Values work	Values & behaviours work	N	
7.57	**W18**	**Continue with efforts to recruit and retain staff (7.57)**	TA/JH/RA	Closed No Further Action			12/08/2020	Mainitning adequate staffing levels resulting in delivery of consistent quality of clinical care	Number of staff recruitin within 12 month period		Y	
7.58	**W19**	**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 (7.58)**	SL	01/03/2019	30/07/2020	Y		Benchmark of services where change has occurred	Evidence previoulsy submitted realting to enquiried to exemplar trusts	Draft Materniyt Vision developed and currenlty out for consultation	Y	
7.68	**W20**	**Consider examining other UK maternity serviceus to seek out models for delivery (7.68 previusly covered under Mat Vision)**										
7.68	W20.1a	Consider future visit to Morecombe Bay	MHT	01/06/2020	31/01/2021	N		Learning from services that have experienced rapid improvement programmes	Learning actions reflected into CTMUHB services	Action plan post visit	N	
7.69	**W21**	**Identify and nurture the local leadership talent. (7.69)**				N						

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Safety				
Safe and Effective Care **Workstream Lead: Valerie Wilson**	**Late**	**RCOG Recommendation/Service Improvement Action**		IMSOP Assurance RAG/measure TBC	Monthly Assurance Assessment
	Completed awaiting IMSOP signoff	**New in month**			
	Concerns	**RCOG Action Milestone**			
	On Track	**Additional Action**			
What failings led to the recommendation					

Incident Management

The use of the Datix system was described as being a midwifery role. There was no medical oversight about decisions as to whether or not to recommend an investigation. The Datix's historically were not regularly reviewed. Of over 600 recent Datix forms listed, only two had been completed by medical staff and neither concerned a clinical matter. How to report a serious incident using the Datix system is not covered during medical staff induction and not discussed with the locum staff. There were no mechanisms in place and no standard process for staff dissemination of learning or feedback from incidents, e.g. patient safety bulletins, newsletters or alerts to bring patient safety to the attention of clinical staff. There were no immediate debriefs in the maternity areas after adverse incidents, but these did occur in the neonatal departments and in A&E.

Serious Incident Investigation

A number of SI investigation outcome forms used in the new review process were reviewed. The panel was not seen to be multidisciplinary or to include an external independent member. There was no involvement of colleagues from anaesthetics and involvement of paediatrics was infrequent and minimal. The assessors found no evidence in documents or during interviews of the outcome of clinical incident investigations having been used in feedback to front-line clinical staff to assist learning and change in practice. Nothing was made known across the service or included in any kind of report, newsletter or update. A number of staff confirmed that they had never seen any information regarding the outcome of SI investigations, even ones in which they had direct involvement. There was no apparent requirement for the outcomes and learning from SI investigations that consultants had been involved in to be included in a consultant's annual appraisal data file.

The assessors were told that women or their partners were not involved in the investigation process and did not always receive a copy of the final RCA report. The assessors were told that all SIs were signed off by the Chief Executive before they went to the Welsh Government, which sometimes delayed the process, but the assessors saw no standing instruction to that effect. Very few staff had had training in RCA methodology within the last year. Of the staff interviewed only one person had received RCA training. From the information provided it would appear that the maternity service has a very generous establishment of consultants for its size (12 consultants for a rate of approximately 3,700 births per annum), therefore, it is difficult to assess why governance responsibilities cannot be fulfilled. From the two sets of notes and investigation pro formas reviewed for neonatal care, there was minimal involvement of paediatric staff in the investigation and, in at least one case, previously unidentified suboptimal neonatal care is probable. There were highly conflicting accounts as to whether paediatric consultants attended maternity governance meetings, or if such meetings even existed. This lack of engagement of paediatric staff in maternity governance arrangements may arise from the services being in separate directorates with separate management.

RCOG	Ref	Actions required	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	Date verified by panel	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
7.1	**S1**	**Urgently review systems in place for (7.1)**										
7.1	S1.1a	data collection	NL/MT/VW	01/01/2020	30/10/2020	N		The service will develop a systematic approach to data validation to ensure that review/investigation and enquirey is based on robust information	Standardised metrics for review • Dashboard • Audit • Research • National benchmarking • improvements	Paper submitted to exec board for funding has been approved.	N	
7.1	S1.2a	clinical validation		01/01/2020	30/10/2020	N					N	
7.1	S1.3a	checking the accuracy of data used to monitor clinical practice and outcomes		01/01/2020	30/10/2020	N					N	
	S1.3b	Review 2019/20 Audit Cycle & 2021 National Audit		01/01/2019	01/01/2021	N					N	
	S1.3c	HB to Produce a report on Data Quality in the Annual Quality Statement		01/04/2020	01/04/2021	N					N	
	S1.3d	Establish sub committee for monitoring systems and processes in place relating to data quality		01/07/2020	01/08/2020	Y					N	
	S1.3e	Align to All Wales review of MITS & Badgernet		01/01/2020	01/01/2021	N					N	
7.1	S1.4a	what information is supplied to national audits		26/05/2020	30/10/2020	N					N	
7.1	S1.5a	Perinatal mortality reporting including EMBRACE/EBC		01/06/2020	30/09/2020	N				Pilot of new safety report with standardised metrics to include EMBRACE/EBC	N	
7.7	**S2**	**Ensure an environment of privacy and dignity for women undergoing abortion or miscarriage in line with agreed national standards of care (7.7)**										
7.7	S2.1a	Awaiting outcome of localities decision in order to commence service review	SW	01/01/2020	30/09/2020	N		Women experience early pregnancy care are treated with compassion and privacy and dignity is maintained at all times	• Reduction in complaints • Improvement in positive women's feedback • Plan for women's engagement	Evidence of business case Evidence of escalation Evidence of wide communication	N	No dedicated space on PCH site. Business case has been developed. Flagged as slippage at MIB, QSR & IMSOP
7.7	S2.1b	please see womens experience for actions relating to experience of early pregnancy loss				N				see E3.7	N	
7.7	S2.1c	Recurrent miscarriage clinic	AK	01/01/2020	30/09/2020	N				TBC	N	
7.19	**S3**	**Ensure that a system for the identification, grading and investigation of SIs is embedded in practice, through: (7.19)**										
7.19	S3.1a	appropriate training to key staff members	ZA/ KG/ VW	01/01/2020	03/08/2020	Y		Embed a robust process to reduce the occurrence of avoidable harm.	• Reduction of reported harm • Timely management of incident/SI's/complaints	Evidence of toolkit Number of staff trained to date	Y	Val to discuss with kathy - assurance around evidence
7.19	S3.1b	making investigations multidisciplinary and including external assessors		01/01/2020	31/12/2020	N					N	
7.19	S3.1c	Ensure flow chart clearly outlines process		01/01/2020	31/12/2020	N					N	
7.19	S3.1d	Utilisation of Organisations SI toolkit		01/04/2020	31/12/2020	N					N	
7.19	S3.1e	All relevant staff to undertake SI training		01/01/2020	31/12/2020	N					N	
7.19	S3.1f	introduce impact assessment to ensure appropriate learning		01/06/2020	31/12/2020	N					N	
7.19	S3.1g	Use HIW feedback		01/01/2020	31/12/2020	N					N	
7.20	**S4**	**Actively seek to remove the 'blame culture' to allow all staff to develop a willingness to report and learn from SIs**										
7.20	S4.1a	Develop and implement as staff questionnarie focusing on the process of SIs	BT	01/05/2020	30/09/2020	N				Feedback and Results from questionnaire	N	
7.20	S4.1	Further actions to be developed folowing analysis of questionnaire		01/05/2020	30/12/2020	N						
7.23	**S5**	**Improve learning from incidents by sharing the outcomes from SIs on a regular basis and in an appropriate, regular and accessible format**	ZA	Closed No Further Action			12/08/2020			Safety breifings MIB & QSR reports Analysis and themes from staff questionnaire in respect of SIs	Y	
7.31	**S6**	**Ensure a robust plan of births anticipated in each midwifery led unit and consultant led unit is undertaken**										
7.31	S6.1a	ensure involvement of paediatric staff for all future service design reviews and actions	VW	01/08/2020	30/10/2020	N					N	
7.31	S6.1b	develop an all service system to ensure planned bookings are reviewed and service is responsive to changes in flow		01/09/2020	01/12/2020	N					N	
7.51	**S7**	**Ensure responses to complaints and concerns is core to the work being undertaken to improve governance and patient safety**										
7.51	S7.1a	Review and enhance staff training on the value of listening to women and families		01/01/2020	31/12/2020	N					N	

7.51	S7.1b	Review the process of investigation of concerns, compiling responses, handling 'on the spot' issues and ensure that all responses and discussions are informed by comprehensive investigations and accurate notes		01/01/2020	31/12/2020	N					N	
7.51	S7.1c	Prioritise the key issues that women and families have highlighted to improve the response		01/01/2020	31/12/2020	N					N	
7.51	S7.1d	Ensure that promises of sharing notes and providing reports to families are delivered	SF	01/01/2020	31/12/2020	N					N	
7.51	S7.1e	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		01/01/2020	31/12/2020	N					N	
7.51	S7.1f	Review the learning from the SIs in relation to misdiagnosis, failure to seek a second opinion and inappropriate patient discharge		01/01/2020	31/12/2020	N					N	
	S8	**Raise awareness of incident reporting by Identify and implement a staff training package so that all staff are aware of how to report an incident (aligns to 7.19, 7.20, 7.21, 7.22, 7.23)**		01/06/2019	01/06/2019	Y						
	S8.1a	scope potential for electronic version	TBC	01/06/2019	31/12/2020	N		Prioritising consistant inclusive approach to ensure maximum reporting levels	100% training compliance	Training Report Incident reporting Training needs analysis Guidance/policy/sop	N	
	S8.1b	Ensure incident reporting training is added the the maternity/neonatal training needs analysis		01/06/2019	31/12/2020	N					N	
	S8.1c	Develop Incident reporting guidance to align to corporate process inclusive of service specific trigger lists (align to all wales trigger list for maternity)		01/06/2018	31/12/2020	N					N	
	S9	**Management of No/Low harm incidents (aligns to 7.19, 7.20, 7.21, 7.22, 7.23)**		01/10/2018	01/10/2018	Y						
	S9.1a	Ensure included in induction for newly appointed managers	TBC	01/11/2019	31/012/2020	Y		Will develop a clear and consistant approach to underpin incident management in the local areas	100% training compliance	Training attendance Band specific training programme	N	
	S9.2	**Develop quality assurance process to monitor appropriate management of No/Low harm incidents**		01/11/2018	01/11/2020	Y		To ensure robust mangement of incidents throughout the operational/MDT team	TBC % of QA tool	Incident Flow chart Standardised Safety Report	N	
	S9.4a	Develop QA tool including assurance measure		01/11/2018	01/11/2020	Y						
	S9.4b	standardised management of low/no harm transferred to local managers following training		01/11/2018	01/11/2020	Y						
	S9.4c	Include QA in standardised incident reporting		01/11/2018	01/11/2020	Y						
	S10	**Management of moderate and above incidents (Aligns to 7.19, 7.20, 7.21, 7.22, 7.23)**										
	S10.1a	Develop Senior MDT weekly review meeting	TBC	01/06/2020	30/09/2020	Y		To support rapid response to moderate and above harms	100% moderate and above incidents reviewed within 1 week by Senior MDT	TOR Redacted examples of pre meet info Safety report showing moderate harm	N	
	S10.1b	Identify appropriate membership and intiate meeting		01/06/2020	30/09/2020	Y					N	
	S10.1c	Develop TORS - aligned to corporate process and other internal review meetings (ATTAIN, PRMT)		01/06/2020	30/09/2020	Y					N	
	S10.1d	Include moderate in harm /reporting (see S5)		01/06/2020	30/09/2020	Y					N	
	S11	**Management of serious Incidents requiring root cause analysis (Aligns to 7.19, 7.20, 7.21, 7.22, 7.23)**										
	S11.1a	Implement the Health Board Serious Incident toolkit	TBC	01/04/2020	01/04/2020	Y		To ensure robust managagement and high quality responses to serious incidents	100% SI's proceed to final executive sign off	SI Toolkit training attendance sheets SI sign off process map Breifing following lookback exercise Examples of standardised safety report	Y	Will be told which 5 SI cases to review
	S11.1b	Benchmark against the toolkit to develop local training /awareness for MDT teams		31/07/2020	31/07/2020	Y					Y	
	S11.1c	Increase number of staff trained to undertake root cause analysis (all consultants and band 7's and above)		03/03/2020	03/03/2020	Y					Y	
	S11.1d	Identify robust process for senior team quality assurance of all RCA prior to corporate sign off	VW/JH	01/04/2020	TBC	N					N	
	S11.1e	undertake lookback exercise on all Si's post Oct 18	TBC	01/04/2020	31/07/2020	N					N	
	S11.1f	Devleop SBAR/action plan based on the look back exercise		01/04/2020	31/07/2020	N					N	
	S11.1g	Provide 5 SI's for external scrutiny		TBC	TBC	N					N	
	S11.2	**Develop process to monitor action plan completion**		01/09/2020	31/12/2020	N		To ensure all actions arising from recommendations are completed and therefore recurrance is prevented	100% SI action plans completed within agreed timeframe	Briefing following review of open action plans evidence of compliance with KPI in month Safety Report	N	
	S11.2b	Undertake review to identify open action plans arising from clinical incidents and develop remedial action plan		01/04/2020	01/04/2020	N						
	S11.2c	include action plan closure monitoring in monthly safety report		01/04/2020	TBC	N						
	S11.3	**Improve family engagement in serious incident investigations**		01/10/2018	01/10/2018	N						
	S11.3a	Develop plan to identify potential engagement points during investigation		20/07/2020	31/07/2020	N		To ensure families are able to share perception and concerns to inform the investigation	100% families offerred inclusion in the SI process	Evidence of meetings/redacted timelines /action plans(if available)	N	
	S11.4	**Improve the investigation process for staff**	BT	01/07/2020	01/07/2020	N		To ensure staff feel supported and informed during investigation process	Improving perceptions from on-going questionnaires	Questionnaire Agregated questionnaire response Actions arising from findings	N	
	S11.4a	Implement quarterley questionnaire to assess staff perceptions of involvement of serious incidents		01/06/2020	30/09/2020	N						
	S11.4b	review current staff communication to ensure sensitive and timely support and feedback for staff involved in serious incidents		01/09/2020	31/10/2020	N						
	S12	**Develop standardised incident reporting template including identification of harm measure and themes identification (Aligns to 7.19, 7.20, 7.21, 7.22, 7.23)**										
	S12.1a	Identify corporate safety reporting metrics	TBC	03/08/2020	01/10/2020	N		To ensure accurate measure of harm and indetification of themes and trends to support perpetual improvement cycle	Standardised reporting template used 100%	Blank template 3 months Safety reporting	N	
	S12.1b	Develop local safety reporting metrics to align to corporate metrics with clear governance process to establish 1 source of truth		03/08/2020	01/10/2020	N					N	
	S12.1c	Scope potential for electronic version/dashboard to enable robust disagregation process		03/08/2020	01/10/2020	N					N	
	S12.1d	Arrange staff engagement meeting to introduce the report /dashboard and explain local responibilities		03/08/2020	01/10/2020	N					N	
	S13	**Develop and implement directorate wide group to review monthly learning and oversee production of staff communications and to assess the impact of learning**										
	S13.1a	Identify group members		01/09/2020	30/09/2020	N					N	
	S13.1b	Develop TOR with agreed minimum outputs		01/09/2020	30/09/2020	N					N	

	S13.1c	Agree branding for messaging and develop templates for monthly newsletter, safety briefings/makes safes, handover news	VW	01/09/2020	30/09/2020	N		To ensure learning is effective and widely shared with staff	100% agreed minimum outcome from TOR	Newsletter Handover news Impact assess via minutes TOR	N	
	S13.1d	Identify hot topics for annual updates		01/09/2020	30/09/2020	N					N	e Neonates are included in all engagement and le
	S13.1e	Develop impact assessment tool for assessment of learning to prevent recurrance		01/09/2020	31/10/2020	N					N	
	S13.1f	Identify resource for supporting the initiative		01/09/2020	30/09/2020	N					N	
	S13.1g	Align learning from the IMSOP case review recommendations into the learning process		01/09/2020	30/09/2020	N					N	
	S13.1h	Launch new process		01/09/2020	31/10/2020	N					N	
	S14	**Align Maternity Risk Management policy to any planned HB wide changes to risk management**		01/07/2018	01/07/2018	Y						
	S14.1a	Identify changes and benchmark Maternity Policy, ratifiy via guideline management process	VW	30/09/2020	30/11/2020	N		Robust Risk management will ensure recognition and effective management of all threats and opportunities that may have an impact on the services, and therefore Health Boards ability to deliver its statutory responsibilities and the achievement of its objectives and values. Thereby	100% complaince with Risk Strategy	Standardised Safety report Maternity Risk Management Policy TOR Agenda/minutes service level safety Meeting/Directorate Quality and Safety Meeting Staff Comms Briefing paper following deep dive	N	
	S14.2	**Agree and implement local risk management process**		01/09/2020	30/10/2020	N					N	
	S14.2a	Review and refresh local risk management process - ward to board to include standardised reporting in repect of managing risk and the risk register		30/09/2020	30/10/2020	N					N	
	S14.2b	Implement local level Risk Management Group with agreed TOR (consider including in Safety week of WESEE meeting structure)		30/09/2020	30/10/2020	N					N	
	S14.2c	Develop staff communications to include 'top 3'		30/09/2020	30/10/2020	N					N	
	S14.2d	undertake deepdive of all current risks		30/09/2020	30/10/2020	N					N	
	S14.2e	Develop and implement Risk Management package for those managing risk		30/09/2020	30/10/2020	N					N	
	S15	**Improve oversight and practice relating to Health and Safety Management (to include Infection Prevention)**										
	S15.1a	Review health board Health and Safety processes to undertake benchmarking process	TA	01/10/2020	31/12/2020	N		Ensure high levels of compliance with Health and Safety standards to maintain safe practices for patients and staff	100% compliance with Health and Safety audit and assurance process	Briefing paper following review proform for audit and assurance process Staff communications Monthly reports	N	
	S15.1b	Identify health and Safety Leads and establish clear roles ad expectations and any development needs		01/10/2020	31/12/2020	N					N	
	S15.1c	Develop on-going audit and assurance process in respect of H+S		01/10/2020	31/12/2020	N					N	
	S15.1d	Develop staff communications to raise awareness and highlight any areas needing improvement		01/10/2020	31/12/2020	N					N	
	S15.1e	Ensure H+S included in the standardised reporting process		01/10/2020	31/12/2020	N					N	
7.21	**S16**	**Imrove incident reporting**										
7.21	S16.1a	December follow up	VW	01/12/2020	01/12/2020	N	03/08.2020				N	

Effectiveness					
Safe and Effective Care **Workstream Lead: Valerie Wilson**	**Late**	**RCOG Recommendation/Service Improvement Action**		IMSOP Assurance RAG/measure TBC	Monthly Assurance Assessment
	Completed awaiting IMSOP signoff	**Action Header**			
	Concerns	**Action Milestone**			
	On Track	**New Action**			
What failings led to the recommendation					
Guidelines To ensure that practice meets national standards, a system of agreed guidelines and standard operating procedures must be in place, which must be regularly reviewed and its application monitored by clinical audit. The assessors were provided with examples of clinical guidelines used by the service, which followed a standard format. However, some were out of date showing that review was required in 2016. The assessors were told that all of these guidelines were available online. The assessors were not able to find any evidence that these were consulted on by any staff groups or that staff were involved in setting the standards for practice. The assessors found no evidence of any clinical audit of performance against guidelines. There are no guidelines as to when to call a paediatric consultant. **Audit** There have been very few audits of unexpected admissions to the neonatal units or of transfers out, and paediatric leadership could not give a credible account of the reasons for these events, or attempts to work with maternity services on quality improvement in this regard. The standard systems of data collection, validation and clinical audit, which the assessors would expect to see in a maternity unit, were not in place. The assessors found no evidence of a functioning system of clinical audit and, therefore, could not be assured that any of the data supplied to the current governance system gave a true picture of the service or had undergone any clinical scrutiny or validation. There was no evidence of a functioning clinically led system for assessing the quality or safety of the service. There was no evidence of any audit process of any kind being in routine use for simple tasks such as hand washing, VTE prophylaxis or catheter care. There have been no actions to achieve The Bliss Baby Charter accreditation.					

RCOG	Ref	Actions required	Responsible Lead	Start Date	Completion date	Completed? (Y/N)	Date verified by panel	Expected outcomes/ Benefits	KPI/ Measure	Evidence/ Output	Evidence Received	Comment/Changes in month
7.2	E1	**Identify nominated individuals (consultant obstetric lead and senior midwife) to ensure that all maternity unit guidelines are: (7.2)**										
7.2	E1.1a	up to date and regularly reviewed	VW/KG	Closed No Further Action			03/08/2020	Consistant oversight and assurance of on-going guideline review and implementation to ensure high clinical standards and quality of care	100% guidelines i100% guidelines in date reported to Directorate Quality and Safety Group 100% guidelines available for staff in the electronic repositories vailable for staff in the	Minutes of meetings Emails evidencing MDT engagement Evidence of risk newsletter with updates on new guidelines for staff TOR & minutes of guidelines oversight group	Y	
7.2	E1.1b	are readily available to all staff, including locum staff and midwifery staff									Y	
7.2	E1.1c	have a multi-disciplinary approach									Y	
7.2	E1.1d	are adhered to in practice									Y	
7.2	E1.1e	Complete backlog of guidelines requiring development									Y	
7.2	E1.1f	Develop guidelines oversight group									Y	
7.2	E1.1g	Develop three year formward plan for guidance review									Y	
7.25	E2	**Appoint a consultant and midwifery lead for clinical audit/quality improvement with sufficient time and support to fulfil the role to ensure: (7.25)**										
7.25	E2.1a	that clinical audits are multidisciplinary		01/01/2020	31/07/2020	Y	12.08.2020	To further improve the audit process in terms of engagement, clinical improvements and shared learning to support the ongoing development of effective and safe care	100% audit completed in time 100% actions plans completed in time 100% audit findings shared	FAP TOR Minutes Governance day agenda Newsletter Audit presentations	Y	
7.25	E2.1b	that that there is a clinically validated system for data collection		01/01/2020	31/07/2020	Y					Y	
7.25	E2.1c	that the lead encourages all medical staff to complete an audit/quality improvement project each year to form part of their annual appraisal dataset		01/01/2020	31/07/2020	Y					Y	
7.25	E2.1d	sharing of the outcomes of clinical audits and the performance against national standards		01/01/2020	31/07/2020	Y					Y	
7.25	E2.1e	Appoint band 6 midwife to support audit programme		01/01/2020	31/07/2020	Y					Y	
7.25	E2.1f	Use AMAT to capture Audit activity including national guidelines		01/01/2020	31/07/2020	Y					Y	
7.25	**E2.1g**	December follow up	VW	01/12/2020	01/12/2020	N	01/12/2020				N	
	E2.3	**Implement electronic audit management tool**		TBC	TBC	N					N	
	E2.4	**Establish Audit Group**		26/06/2019	26/06/2019	Y					Y	
	E2.4a	Identify group members		26/06/2019	26/06/2019	Y					Y	
	E2.4b	Develop TOR, Agenda, and meeting schedule		26/06/2019	26/06/2019	Y					Y	
	E2.4c	commission group		31/07/2020	31/07/2020	Y					Y	
	E2.4d	Identify joint working group to adress PMRT backlog		31/07/2020	31/07/2020	Y					Y	
	E2.4e	Develop monthly PMRT process		31/07/2020	31/07/2020	Y					Y	
	E2.4f	Develop monthly feedback and align via the learning to prevent occurance' group		0/09/2020	31/12/2020	N					N	
	E3	**Maternity Assessment Tool (7.25)**										
	E3.2a	Develop and implement Maternity Assurance Tool		01/09/2020	31/12/2020	N		High quality premises and working practices	100% completion of assessment schedule RAG rating compliance TBC	Assurance tool Assurance schedule Reports Action plans	N	
	E3.2b	review current Health Board assurance audits		01/09/2020	31/10/2020	N					N	
	E3.2c	assimilate HB process with maternity specific audits		01/09/2020	31/11/2020	N					N	
	E3.2d	develop and implement assurance review process for band 7's and above		01/10/2020	31/12/2020	N					N	
	E4	**Establish research programme**										
	E4.1a	Employ Research Midwife	JP	31/05/2020	31/05/2020	Y		To establish Maternity Services CTM as a centre of innovation	TBC	Research programme publications	Y	
	E4.1b	Develop research programme		01/05/2020	31/12/2020	N					N	
	E5	**Integrated Assurance Framework**										
	E5.1a	Ensure effective process for reporting validated data to ensure robust assurance	VW	01/06/2020	31/10/2020	N		Standardised ward to board reporting and assurance framework to ensure robust oversight of services	100% compliance with meeting schedule 100% quoracy compliance 12 Handover News per annum	Integrated Assurance Framework infor graphic TOR Job desciption Agendas Attendance monitoring Standardised reporting Staff Comms	N	
	E5.1b	Develop assurance framework		31/07/2020	31/07/2020	Y					Y	
	E5.1c	Review TOR, agendas, membership of existing assurane forums		01/06/2020	31/10/2020	N					N	
	E5.1d	Develop revised TORs with clear responsibilities and escalations		01/06/2020	31/10/2020	N					N	
	E5.1e	Develop clear KPI and outcome assessment for all assurance forum reporting aligning to corporate assurance function		01/06/2020	31/10/2020	N					N	
	E5.1f	Meet with forum chair persons to support new approach		01/06/2020	30/11/2020	N					N	
	E5.1g	Identify adminstrators and develop administrator role		01/06/2020	31/10/2020	N					N	
	E5.1h	Develop staff communication to share new process		01/06/2020	30/11/2020	N					N	
	E5.1i	Await outcome of ILG review to confirm site based reporting to locality boards		01/06/2020	31/10/2020	N					N	
	E5.1j	Await outcome of NN review/decision to align to framework		01/06/2020	31/10/2020	N					N	
	E5.2	Ensure operational teams engaged in assurance framework		01/06/2020	31/10/2020	N					N	
	E5.2a	Develop weekly WESEE meetings for operational staff		01/06/2020	31/10/2020	N					N	
	E5.2b	Develop standardised agendas for weekly meetings		01/06/2020	31/10/2020	N					N	
	E5.2c	Invite business partners/speciality Leads to attend on monthly cycle		01/06/2020	31/10/2020	N					N	
	E5.2d	Develop 'Handover News' to ensure ward to board information flow		01/06/2020	31/10/2020	N					N	
	E5.2e	Await outcome of NN review/decision to align to Wesee meeting structure		01/06/2020	31/10/2020	N					N	