Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Ysbyty Ystrad Fawr Hospital, Midwifery Led Unit - Birth Centre, Aneurin Bevan University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Ysbyty Ystrad Fawr within Aneurin Bevan University Health Board on the 19, 20 and 21 August 2019. This inspection is part of HIW's national review of maternity services across Wales[1].

The following hospital wards were visited during this inspection:

- Midwifery led unit with a capacity of six beds with two birthing pools
- Antenatal clinic.

Our team, for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one consultant obstetrician and two midwives) and one lay reviewer. The inspection was led by a HIW inspection manager.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

[1] https://hiw.org.uk/national-review-maternity-services

2. Summary of our inspection

Whilst we identified some areas for improvement, overall we found evidence that the service provided respectful, dignified, safe and effective care to patients.

There were some good arrangements in place to support the delivery of safe and effective care and positive multidisciplinary team working.

This is what we found the service did well:

- Women and their families rated the care and treatment provided during their time in the unit as excellent
- We observed professional and kind interactions between staff and patients, and care was provided in a dignified way
- There was a safe and robust process inspected for medicines management
- Documentation was of a high standard
- Good support provided by specialist midwives in areas such as health promotion
- Excellent health promotion information was seen throughout the unit
- Care given was to a high standard with clear continuity in care planning
- The unit was found to be clean, welcoming and suitable to meet the needs of mums to be and their families.

This is what we recommend the service could improve:

- Creation of a standard operating procedure for the monitoring of fetal heart rate during complications in labour
- Regular date checking of stock stored within infrequently used family rooms
- Storage of hazardous substances.

3. What we found

Background of the service

Ysbyty Ystrad Fawr is located within Aneurin Bevan University Health Board. The health board was established on the 1 October 2009 and covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

The health board has a total catchment area for healthcare services containing a population of approximately 600,000. Acute, intermediate, primary and community care and mental health services are all provided. Services are delivered across a network of primary care practices, community clinics, health centres, one learning disability hospital, a number of community hospitals, mental health facilities, one local general hospital and three district general hospitals; Royal Gwent, Nevill Hall and Ysbyty Ystrad Fawr.

Maternity services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provides care to women who chose to birth in the health board facilities who reside outside the geographical boundary.

The health board averages around 6,000 births per year, with around 307 of these at Ysbyty Ystrad Fawr.

Women who birth within the health board have the choice of four birth settings. These include homebirths, a free-standing midwife unit, midwife led care at an alongside midwife unit and an obstetric unit. A freestanding midwifery led unit (birth centre) is based at Ysbyty Ystrad Fawr Hospital and comprises of three birthing rooms, two birthing pools and four postnatal family bedrooms.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients were positive about their overall experience of the service. Most patients told us they were happy with the care and support provided to them. Without exception, patients also told us that they had always been treated with dignity and respect.

We observed polite, friendly and supportive interactions between staff and patients.

We identified improvements regarding the monitoring of fetal heart rate when abnormality is detected in labour and the need for a policy to ensure consistency in care given.

We recommended that information on how patients, their families and carers can raise concerns about their care is readily available and clearly displayed.

Patients and families should also be made aware of the Community Health Council (CHC) for advocacy and support.

During the inspection, we distributed HIW questionnaires to patients, families and carers to obtain their views on the standard of care provided to patients. A total of thirteen questionnaires were completed. We also spoke on average, with eight patients each day during the inspection.

Patients who completed questionnaires rated the care and treatment provided during their stay in the maternity unit as excellent (scores were detailed as eight out of ten and above). Patients and their families who we spoke with also said they had a good experience in the unit. Patient comments included:

> *"All the staff have been very supportive, informative and allowed us to make informed decisions".*

> *"Midwife stayed beyond her working hours was amazing".*

"Staff go above and beyond, patient care is consistent and patients are very happy with the care that they receive".

"We are confident in the midwives and medical staff that look after us".

"Midwives and medics give exceptional care".

Staying healthy

We saw that a variety of information was displayed for patients on notice boards and in leaflets. Information in relation to breastfeeding and skin to skin advice was displayed in the corridors, to inform patients about the benefits of both breastfeeding and skin to skin contact to help them make an informed decision about their care.

We also saw information in relation to smoking cessation throughout the unit. We were also told that the health board had recently employed three smoking cessation advisors to provide support and information to patients.

We saw a plaque on the wall stating the unit was UNICEF[2] baby friendly accredited in 2017. It was confirmed that the accreditation was reviewed every three years confirming compliance in this.

Hand hygiene posters and hand washing guides were displayed in patient toilets.

Dignified care

During the course of our inspection, we saw many examples of staff being kind and compassionate to patients. We saw staff treating patients with respect, courtesy and politeness at all times. The majority of comments within the patient questionnaires were very positive.

We also saw staff promoting privacy and dignity when helping patients with their personal care within the antenatal clinic. We reviewed care documentation and did not find any areas of concern regarding dignified care.

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[2] https://www.unicef.org.uk/babyfriendly/ - The Baby Friendly Initiative is transforming healthcare for babies, their mothers and families in the UK, as part of a wider global partnership between the World Health Organization (WHO) and Unicef.

There were en-suite facilities within each of the birthing and postnatal rooms to support privacy and dignity during the patient's stay.

We saw that staff maintained patient privacy when communicating information. We noticed that it was usual practice for staff to close doors of consultation rooms providing care and support to protect their privacy and dignity.

Half of the patients who completed questionnaires told us they saw the same midwife in the birthing unit as they did at their antenatal appointments. The majority of patients were six to twelve weeks pregnant when they had their booking appointment and there were mixed comments regarding the patients being offered a choice about where to have their baby.

The staff within the unit advised that they would be able to appropriately care for any recently bereaved parents. We were told that any of the postnatal rooms would be altered and used if needed to care for bereaved families in a calm and welcoming environment. We were also told that the service had an appointed bereavement midwife who was the lead for the whole health board. The hospital also provided a chaplaincy service and there was a multi-faith hospital chapel for the use of patients and their families. We were also told about arrangements to enable patients from different faiths to access the prayer rooms to meet their spiritual needs

Patient information

We found that directions to the maternity unit were clearly displayed throughout the hospital. When access was required out of core hours, signs were clearly displayed to direct people appropriately to the birthing unit via an outside access door.

Information was predominately available in English, with limited information in Welsh. We were told by senior departmental managers that a rolling programme was in place to ensure that all information was bi-lingual and current information was in the process of being translated.

Notice boards throughout the unit highlighted a wide range of health promotion, such as breastfeeding, Bee Knowledgeable[3], Bump, Baby and Beyond[4], Healthy Start[5] and smoking cessation. Daily staffing details of the unit was also clearly displayed.

As this was a freestanding midwifery led unit[6], visiting times were flexible. All rooms were private meaning that birthing partners or other family members could be present before, during and after giving birth.

Staff we spoke with were aware of the translation services within the health board and how they were able to access these. Welsh speaking midwives were also identifiable by the Welsh speaker logo[7] on uniform.

Communicating effectively

Overall, patients seemed to be positive about their interactions with staff during their time in the unit. Most patients who completed a questionnaire told us that they could always speak with staff when they needed to. The majority of patients also said they had been listened to by midwifery and medical staff during their stay.

However, four of the 13 questionnaires completed also highlighted that they were not asked by the midwife about how they were feeling and coping emotionally in the antenatal period.

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[3] Bee Knowledgeable is an internal health board maternity initiative to promote perinatal mental health awareness and to offer support and guidance where required.

[4] Bump, Baby and Beyond is a book is written by parents, health professionals and child psychologists and has a wealth of useful information intended to support parents all the way from the early stages of pregnancy, through to the early days with baby and into the toddler years.

[5] Healthy Start is a NHS and Change 4 Life initiative to offer mum's to be and families free milk, fruit, vegetables and vitamins.

[6] Freestanding midwifery led unit provides a home from home environment, enabling women to give birth within a non-clinical setting.

7 The Iaith Gwaith brand is an easy way of promoting Welsh services by identifying the Welsh speakers within a team. If someone is wearing a badge, or lanyard, this shows that they can have a conversation in Welsh.

We saw that staff on the birthing unit met twice daily, at shift change over time. This was in order to communicate and discuss patient needs and plans with the intention of maintaining continuity of care. Information was also captured in handover sheets, to ensure all staff were kept up-to-date with relevant information, however at the time of the inspection there were no patients present within the birthing unit in labour or postnatal.

We were also advised that there is a health board maternity Facebook social media page which had been created to allow for communication with new mothers and sharing of experiences and feedback. We were told that to date the social media page had received 8,000 hits.

Timely care

Although there were no patients seen in the birthing unit at the time of the inspection, we were told by staff that they would always do their utmost to ensure patients were regularly checked for personal, nutritional and comfort needs. This was also seen within the patient's records we reviewed.

Call bells were seen to be easily accessible within the unit and there was a full selection of hot and cold drinks and foods available on request.

We saw that patient observations were recorded in a recognised national chart to identify patients who may becoming unwell or developing sepsis. Staff were aware of the screening tool and reporting system for sepsis, and allowed for appropriate and timely action to be taken.

The staff we spoke with on the birthing unit told us that they were able to achieve high standards of care during their working day.

Individual care

Planning care to promote independence

We found that facilities were easily accessible for all throughout the unit.

The use of a language line was available for those patients whose first language was not English, meaning that they were able to access care appropriate to their needs.

We looked at a sample of patient records within the unit and found evidence that patient's personal beliefs and religious choice were captured during antenatal

appointments, with a view to ensuring they were upheld throughout their pregnancy, during labour and postnatal care. The care plans also reflected the emphasis on promoting people's independence based on their assessed abilities.

Carers were encouraged and welcomed to stay within the unit, to support patients who may have additional needs.

People's rights

We found that family/carers were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. These arrangements were recorded in patients' notes. This was to ensure that all members of the team were informed of patient preferences.

Both staff and patients told us that open visiting was available, allowing the partner, or a designated other, to visit freely.

All of the birthing rooms were well equipped with a birthing ball, hand rails on the walls and beanbags to help meet the patients' birth choices. Two of the birthing rooms also had plumbed in birthing pools which allowed patients to use the pool during labour.

We were told that to promote the birth options available to patients and to provide information to help them make an informed decision, discussions take place in initial booking appointments and throughout the pregnancy. However, we looked at a sample of patient care records and found limited documentation of discussions held with patients regarding their birth choices.

Improvement needed

The health board must ensure that discussions with patients regarding their birth choices are recorded within patient documentation, so that their preferences can be supported effectively.

Listening and learning from feedback

We saw information leaflets and posters throughout the unit relating to the complaints procedure for patients to follow should they have concerns they wish to raise. Information was also available on raising concerns and advocacy support on the health board's website. We were told that there was a designated midwife lead within the health board who would liaise with the Putting Things

Right[8] team for consideration of formal patient complaints. Staff told us that they did not routinely provide patients with details of the Community Health Council[9] who could provide advocacy and support to raise a concern about their care.

The service also had a process for addressing non-formal complaints, with the intention of resolving them on the ward and at the time of them being raised. Informal complaints could be referred into the service through feedback given by patients to community midwives, health visitors and social media sites. We were told that following a complaint, a consultant midwife would contact patients offering discuss their issues, as well as promoting the formal complaints procedure should they wish to follow this route. We were told that this was used as a way of hopefully addressing any concerns, but also with a view to highlight any practice issues that may need resolving, which was seen to be noteworthy practice.

As a consequence of a review of a neighbouring health board's maternity services[10], we were told that the service was actively trying to promote their social media outlets with a view to obtain patient feedback. We were told that feedback received is presented on a monthly basis to the services clinical governance meetings highlighting any themes or trends.

We saw compliments cards were displayed and there was a graffiti board in the unit which allowed patients to write comments about their care and treatment received. We saw there were many positive comments provided by patients, expressing their thanks to the staff on the unit. However, patients and families may not feel comfortable in including any negative experiences upon the graffiti board. We advised the health board to consider ways feedback could be provided confidentially, including reinstating a comments box.

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[8] http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

[9] http://www.wales.nhs.uk/sitesplus/899/home

[10] https://gov.wales/sites/default/files/publications/2019-04/review-of-maternity-services-at-cwm-taf-health-board_0.pdf

Improvement needed

The health board must ensure patients and families are made aware of the Community Health Council for advocacy and support.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We identified some good processes in place within the unit to support the delivery of safe and effective care.

We found that there were robust processes in place for the management medicines, pain assessment and clinical incidents, ensuring that information and learning is shared across the service.

We identified areas for improvement regarding infection prevention, storage of hazardous substances and the date checking of stock within birthing rooms.

We found patient safety was promoted in daily care planning and this was reinforced within the patient records we reviewed.

The service described good arrangements for safeguarding procedures, including the provision of staff training.

Safe care

Managing risk and promoting health and safety

We found that the unit was visibly well maintained, clean, appropriately lit and well ventilated. The unit was well organised with a maintained stock of medical consumables. Whilst we generally found that safety was observed throughout the unit, we found within both of the birthing pool rooms that cleaning solution was left out on the work surfaces which posed a health and safety risk. This was raised at the time of the inspection and rectified immediately.

We considered the unit environment and found sufficient security measures in place to ensure the safety and security of babies on the unit.

We looked at the arrangements within the unit for accessing emergency help and assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells to summon assistance quickly. We found the emergency trolley, for use in a patient emergency, was well organised and contained all of the appropriate equipment, including a defibrillator. The

emergency drugs were also stored on the emergency trolley and we were assured that daily checks were being maintained on this equipment to ensure it was available and safe for use.

We noted there was appropriate emergency equipment within the birth pool rooms to remove patients quickly from the pool. We were assured that all staff had received appropriate training in the use of this equipment in the case of emergency.

Improvement needed

The health board must ensure that cleaning products are stored appropriately.

Falls prevention

We saw there was a risk assessment in place for patients using birthing pools across the unit. We were informed that any patient falls would be reported via the health boards electronic incident recording system, and their incident reporting system would be followed to ensure lessons learnt recorded and acted on appropriately.

Infection prevention and control

We found that the clinical areas of the unit were clean and tidy and we saw that personal protective equipment was available in all areas and was being used by all healthcare professionals. Patients who completed a questionnaire and patients we spoke with said they thought the unit was well organised, clean and tidy.

During the inspection, we observed all staff adhering to the standards of being Bare Below the Elbow[11] and saw good hand hygiene techniques. Hand washing and drying facilities were available, together with posters displaying the correct

[11] Best practice is for staff involved in direct patient care to be bare below the elbow, this includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), wrist watches, nail polish or false nails.

hand washing procedure to follow as a visual prompt for staff. Hand hygiene gels were available throughout the unit.

We were also assured that infection prevention and control training compliance was to a high standard, and any concerns that were raised regarding infection prevention and control would be escalated to senior members of staff. We saw results from an infection control audit which has recently had been carried out by the health board. This audit showed that compliance with infection control was high and any work required was appropriately dealt with in a timely manner. However, we found two reclining chairs in the postnatal rooms to be broken and had splits within the material which could pose a risk to infection prevention and control.

We saw there were designated labels on equipment to signify that it was clean and ready for use and we found that cleaning schedules for the unit were in place and up-to-date.

All rooms within the unit were seen to be en-suite room available for patients use should there be a requirement for barrier nursing, to help prevent infections being transferred to other patients.

We were told that the birthing pool was cleaned every day, and a weekly check of the water was carried out. These checks ensured that the birthing pool was appropriately cleaned and safe to use.

Improvement needed

The heath board must ensure that reclining chairs within the unit are checked and replaced where required to maintain infection prevention and control.

Nutrition and hydration

At the time of the inspection, no patients were seen within the birthing unit, however we were told that hot and cold food and drink was available 24 hours a day. Staff on the unit had access to facilities to make food and drinks for patients outside of core hours, which allowed for nutritional needs being met throughout the day and night.

Within the antenatal clinic there were facilities available to purchase drinks if required. We were also told by staff that water jugs and tea and coffee facilities were also available in each of the birthing rooms.

In the patient care records we reviewed, we found that patient nutritional and fluid requirements were well documented.

Medicines management

We looked at the arrangements for the storage of medicines within the birthing unit and found that the temperatures at which medicines were stored were consistently checked on a daily basis.

We observed the storage, checks and administration of controlled drugs to be safe and secure. We were assured there were appropriate process and procedures for the management of controlled drugs on the unit.

However, we found there were vials of water for injection and sterile gloves which were out-of-date within the infrequently used birthing rooms which meant they were not safe to use. This was escalated to the midwife in charge immediately and a full review of stocks within the birthing rooms was checked straight away.

We looked at a sample of medication records and saw these had been completed appropriately. They were consistently signed and dated when prescribed and administered.

Pharmacy support was available to the unit and an out-of-hours computerised process was available for staff to check stock and availability of drugs across the hospital during these times, to ensure there were no delays in patients receiving medication. The unit also had access to a stock of take home medication, allowing patients to be discharged in a timely manner.

The health board medicines management policy was available to staff electronically and also stored in a file within the unit areas so this could be easily accessed by staff.

Improvement needed

The health board must ensure that there are regular checks of equipment and materials within all birthing rooms to ensure items are in date and safe for use.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be vulnerable or at risk. All staff we

spoke to confirmed that they had received mandatory safeguarding training within the past 12 months.

Safeguarding training was included in the health boards mandatory study days and we were told that sessions included training and guidance regarding female genital mutilation (FGM), domestic abuse, sexual exploitation and bruises on babies, as well as the procedures to follow in the event of a safeguarding concern.

We were told that formal safeguarding supervision sessions are held regularly and staff are encouraged to discuss issues in a group supervision session. The lead safeguarding midwife was also available for telephone discussions to provide support and guidance to staff on the unit. Formal safeguarding supervision had been recently introduced and was mandatory for staff to attend two sessions per year. We were told that the health board recently started to roll-out this training to community based midwives, with the intention of expanding this across the rest of the service over the year.

There were appropriate procedures in place to alert staff to safeguarding concerns with regards to patients being admitted onto the unit, to ensure care and treatment was provided in an appropriate way.

Medical devices, equipment and diagnostic systems

We considered the arrangements for the checking of resuscitation equipment within both the birthing unit and the antenatal clinic. We were assured that regular checks were being carried out to ensure the equipment was suitable for use.

We also found that regular checks of other pieces of equipment, such as blood pressure machines, had been carried out in a consistent and regular manner.

Effective care

Safe and clinically effective care

The birthing unit had the use of cardiotocography (CTG)[12] to monitor mainly ante-natal patients who attend the unit as day patients. We identified that some staff

[12] A machine used to record the fetal heartbeat, where continuous CTG monitoring is in place

were using this monitor if an abnormality was detected in the fetal heart rate during labour. If concerns with the heart rate were identified, prompt action would be taken, including transferring a patient to an obstetric unit if required. However, we found that there was no standard operating procedure in place to ensure consistency. Whilst we were assured that the appropriate actions were being taken in practice, we felt that a procedure was needed to support patient safety.

We saw that patients within the antenatal clinic unit appeared comfortable and well cared for. We also saw good evidence of medical assessment and treatment plans throughout the patient records reviewed.

We were told by staff that patients within the birthing unit would always be kept comfortable and well cared for. Pain relief would be available to patients during labour, and we saw medication appropriately prescribed in postnatal care and patients receiving it promptly within the patient records we reviewed.

We observed staff effectively prioritising clinical need and patient care within the antenatal clinic. Although there were no patients within the birthing unit at the time of our inspection, it was evident from the patient records we reviewed that clinical needs were prioritised appropriately as part of care planning.

Staff who we spoke to told us that they were happy with the quality of care they were able to give to their patients. Based on discussions with staff and some comments made within the patient questionnaires, we established that staff sometimes work above and beyond what is required of them due to the nature of their role and commitment to it.

Quality improvement, research and innovation

A lead clinical research and innovation midwife was in place, who covered maternity services across the health board. Champion research midwives were also appointed across the service, and were encouraged to get involved in research projects to support the team. The team was involved in research associated with local university projects to support service and patient experience development.

A large element of the team's work involved developing service user engagement. We saw that the service had developed their social media, including a Facebook page as a way of reaching out to patients.

We were also shown evidence of the generic e-mail that had been established. The e-mail would be sent when women initially book their pregnancy in antenatal clinic and would offer support, advice and guidance from that point on.

Information governance and communications technology

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and procedures.

We found that the unit was using a maternity dashboard. This is an electronic tool to monitor the clinical performance and governance of maternity services. This may also help to identify patient safety issues so that timely and appropriate action can be taken to ensure high quality care.

We were also told that all staff within the unit had dedicated computer access details to ensure information governance was maintained to a high standard.

Record keeping

Overall, we found patient records had been well maintained with clear documentation which was completed in a timely manner.

We considered a sample of midwifery antenatal and postnatal patient records within the unit. Records showed that pain was being assessed and managed appropriately. Appropriate risk assessments, including those for deep vein thrombosis, had been completed. However, in some patient records we saw inconsistency of where information was being recorded such as information required to be in care plans was found to be noted on additional notes pages.

Improvement needed

The health board must ensure that patient notes are clearly organised and that concise record keeping is maintained.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Staff were striving to deliver a good quality, safe and effective care to patients within the unit.

Specialist midwives were appointed across the health board and we found them to be useful and knowledgeable resources for the unit teams.

Staff reported that there was good multidisciplinary team working, and we saw evidence to support this.

We found evidence of supportive leadership and management. Staff who we spoke with were generally positive regarding the support they received from senior staff.

Governance, leadership and accountability

The provision of maternity services at Ysbyty Ystrad Fawr is supported clinically, if required, by the obstetric units (units for more complex pregnancies) within the Royal Gwent and Nevill Hall Hospitals. However, we found that Ysbyty Ystrad Fawr was self-sufficient in management, leadership and accountability.

We were told that the health board had planned to centralise the maternity, neonatal and paediatrics services to Llanfrechfa Grange hospital in Newport. However, we were told that Ysbyty Ystrad Fawr will remain a freestanding birth centre as part of the clinical futures programme.

A six-weekly Women and Children's Transition Board meeting is also held by the directorate. This meeting is held with a view to providing a strategic oversight of the service, in relation to the other services within the main hospital sites.

We found that there was good, overall monitoring and governance of the staffing levels of the service, and we were assured that the internal risk register was monitored and acted upon when required.

We also found that there was audit activity taking place which was being monitored and presented upon in appropriate quality, safety and risk meetings and forums.

We were able to see that there was a good level of oversight of clinical activities and patient outcomes. A monthly maternity dashboard was produced, which included information in relation to the whole health board, but also broken down to each hospital. This provided information on the clinical activity on the unit i.e. number and category of births (vaginal, caesarean section, assisted), induction of labour, and also clinical indicators and incidents, such as complaints, investigations, eclampsia[13], intensive care admissions, blood transfusions, neonatal admissions and neonatal morbidity. The dashboard was rated red, amber and green depending upon the level of risk meaning that prioritisation in risk management could be managed appropriately.

In addition, the senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBBRACE)[14] and Each Baby Counts[15] were taken forward in the unit. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies such as MBBRACE, and ongoing work takes place to ensure the unit is in line with the recommendations made.

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in place, who held responsibility for monitoring and reviewing clinical management of multi-disciplinary investigations. All staff we spoke with told us that the organisation encourages them to report errors, near misses or incidents and that these were not dealt with

[13] Eclampsia is the onset of seizures during pregnancy

[14] MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK with the aim of providing robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

[15] Each Baby Counts - the Royal College of Obstetricians and Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

in a punitive manner. However, we were told that not all staff were given the opportunity of non-clinical time, allowing them to review incidents appropriately, which was seen to be good practice.

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead governance midwife also presented themes and trends to this meeting, with the view of highlighting any areas of practice, which were in need of addressing across the heath board. Following this meeting, a monthly feedback newsletter was produced and circulated to all staff, summarising the month's issues. We also saw that this newsletter was used to provide positive feedback to staff, and to highlight where good practice had been evident. Monthly risk meetings were held at Ysbyty Ystrad Fawr where reported incidents, investigations and their findings were discussed in a multidisciplinary format. We saw that minutes were produced and information/learning shared across maternity services across the health board to support changes to practice and learning. This information also included other maternity sites within the health board, with a view to sharing best practice and any learning to improve practice and processes.

Staff and resources

Workforce

Overall, staff we spoke to within the inspection and the majority of those who completed questionnaires told us that they felt fully supported by their senior managers and that peer support was also very good. Staff reported that there was good multidisciplinary working within the service. One staff member who completed a HIW questionnaire commented:

> *"Have always found all of the management team to be supportive both in work related and personal situations".*

The staff we spoke to also told us that the organisation encourages and supports team working.

The majority of staff who completed a questionnaire said they were involved in deciding on changes introduced that affect their work and half of staff said that communications were effective.

We were told by all staff we met that midwifery rotas were well managed within the unit. If there were any shortages of staff cover, community midwives would be called in or senior managers would step in to cover. All the staff we spoke with said there are rarely any issues with staffing coverage and that senior staff manage this well.

We found that there was a process in place for monitoring staff attendance and compliance with mandatory training. Health board mandatory training such as health and safety, fire safety and safeguarding is predominately carried out on-line, and is monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire to ensure they remain within timescales.

The service holds three mandatory maternity related study days across the year. One of the days is practical obstetric and multi-professional training PROMPT training, which is a multidisciplinary training event used to encourage effective multidisciplinary working in emergency situations. All staff we spoke with told us they attend the training when they can and find it very useful. We were shown compliance figures for PROMPT training and were assured that training was appropriately taking place in the correct timescales.

Training included in the other mandatory study days included CTG, safeguarding, incident reporting, basic life support, supervision, public health amongst other topics.

The health board had a lead midwife for practice education/practice facilitator, and part of their role was to monitor compliance with training across the year. We were able to see that a quarterly report is produced for senior midwifery staff to show compliance with the training. Staff are required to book themselves onto the relevant training days and attendance/non-attendance at training is reported to the senior teams.

Three clinical supervisors of midwives were in place across the health board. Their roles were to provide support and professional supervision to midwifery staff. There is a national target to make sure that supervisors meet with midwives for four hours[16] each year. The health board started to monitor compliance with this target during the previous financial year and were continuing to monitor it on an ongoing basis.

The clinical supervisor of midwives was also responsible for carrying out appraisals. We were told that within Ysbyty Ystrad Fawr, all appraisals were up-

[16] https://gov.wales/sites/default/files/publications/2019-03/clinical-supervision-for-midwives-in-wales.pdf

to-date. Staff we spoke to told us they have regular appraisals and they see them as positive meetings to help identify further training opportunities to increase continuous professional development.

We found that there was a good level of support in place from the specialist lead midwives. Whilst they were not based at Ysbyty Ystrad Fawr, we found they made efforts to be visible and approachable to staff within the unit. Information provided to us during the course of the inspection demonstrated that they were knowledgeable about their specialist roles, and they provided support and guidance through study days, supervision sessions and meetings with staff as and when required.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns noted			

Appendix B – Immediate improvement plan

Hospital Inspection: Immediate improvement plan

Service:

Area:

Date of Inspection:

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
No immediate improvements required				

Health Board Representative:

Name (print):

Role:

Date:

Appendix C – Improvement plan

Hospital: Ysbyty Ystrad Fawr

Ward/department: Birthing Unit and Antenatal Clinic

Date of inspection: 19 to 21 September 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that discussions with patients regarding their birth choices are recorded within patient documentation, so that their preferences can be supported effectively.	4.2 Patient Information			
Delivery of safe and effective care				
The health board must ensure that cleaning products are stored appropriately.	2.1 Managing risk and promoting health and safety			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The heath board must ensure that reclining chairs within the unit are checked and replaced where required to maintain infection prevention and control.	2.1 Managing risk and promoting health and safety			
The health board must ensure that there are regular checks of equipment and materials within all birthing rooms to ensure items are in date and safe for use.	2.1 Managing risk and promoting health and safety			
The health board must ensure that patient notes are clearly organised and that concise record keeping is maintained.	3.4 Information Governance and Communications Technology			

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print):

Job role:

Date: