Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Withybush General Hospital / Midwifery Led Unit, Hywel Dda University Health Board

Inspection date: 3 – 4 December 2019

Publication date: 5 March 2020

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80038-245-9

Contents

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 Withybush General Hospital within Hywel Dda University Health Board on 3 and 4 December 2019. The following area was visited during this inspection:

- Midwifery led unit

Our team for the inspection comprised of two HIW inspectors, two midwife peer reviewers and a lay reviewer.

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.

2. Summary of our inspection

Overall, we found that the service provided care in a respectful and dignified way to patients.

However, we identified improvements were required to ensure that the service was providing safe and effective care at all times and in accordance with the Health and Care Standards.

This is what we found the service did well:

- Women and their families were positive about their care and treatment
- We observed staff speaking to patients and visitors in a professional but polite and friendly manner
- Regular parent craft classes are available
- Patient records were being maintained to a good standard
- Patients had good access to perinatal mental health support.

This is what we recommend the service could improve:

- Consistent recording of checks of the temperatures within which medicines and controlled drugs were stored
- Checks on emergency neo-natal resuscitation equipment
- Availability of smoking cessation information
- Birthing pool evacuation training for staff.

3. What we found

Background of the service

Withybush Hospital is located in Haverfordwest in Pembrokeshire and forms part of the health care services provided by Hywel Dda University Health Board (the health board). The health board provides healthcare services to a total population of around 384,000 throughout Carmarthenshire, Ceredigion and Pembrokeshire. It provides acute, primary, community, mental health and learning disabilities services.

The largest hospitals within the health board are Bronglais General Hospital, Glangwili General Hospital and Withybush General Hospital. The health board operates twelve other smaller hospitals.

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

The health board averages over 3,100 births per year with around 140 of these in either the midwifery led unit in Withybush Hospital, or homebirths within the Pembrokeshire area.

Women who give birth within the health board have the choice of four birth settings. These include a homebirth, free-standing midwife unit at Withybush Hospital, an alongside midwife unit and obstetric unit within Glangwili Hospital and Bronglais Hospital. All midwife led intrapartum care settings have access to the obstetric unit when complications arise in labour.

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.

We observed staff speaking to patients and visitors in a polite and friendly manner.

Patients were provided with information about their birth choices, allowing them to make informed decisions about their care.

The environment was clean, tidy and welcoming to patients, partners and visitors.

Birthing rooms were well equipped to support individual choice and to meet the patients' birth choices.

Improvements were needed to the location and availability of health promotion information.

We also found improvements were needed to the provision of information in Welsh and clarity of information around the arrangements of emergency transfers from the unit contained within a birth decision leaflet.

During the inspection, there were no patients in the unit who had recently given birth. We therefore distributed questionnaires to patients at the unit who were attending antenatal appointments to obtain their views on the services provided. A total of six questionnaires were completed. We also telephoned patients who had recently delivered their baby at the unit to obtain their views.

Overall, patients we spoke to and those who completed a questionnaire rated their care and treatment as excellent. Patient comments included the following:

> *"A calming and lovely place to give birth. I had both my children here and received excellent care throughout."*
>
> *"Lovely relaxed atmosphere. Always feel very welcome. Love the birthing pool room and all the relaxation aids provided."*

"All midwives are excellent. It is just a shame the facilities for further care is limited."

Staying healthy

We saw there was a variety of information for patients displayed. Information included meningitis awareness, weight loss and healthy eating. We also saw information on breastfeeding clinics which were available in the local area. This information was located near to the reception desk. However, patients who arrived at the unit were taken directly through to a small seated waiting area within the unit and may not see this. We advised that the patient information should be provided within the seated area to allow patients the opportunity to read the material whilst waiting for their appointments.

We saw details of a smoking cessation practitioner within the unit. We also saw that smoking cessation advice was provided during antenatal appointments in the sample of patient records we reviewed. However, there was no information available for patients relating to smoking cessation. This information would promote the health of patients both during and after pregnancy.

A notice board was located on the wall of the corridor within the unit. The board contained information relating to transfer times from the unit to Glangwili hospital that was out of date. We advised that the notice board could be better used to display health promotion such as breastfeeding and smoking cessation.

We saw a plaque on the wall stating the unit was UNICEF[1] baby friendly accredited in November 2018. Accreditation is reviewed every three years which confirms the unit's compliance with this.

Staff told us they were trained in providing breastfeeding support and additional support was offered to patients in their own homes by community midwives and health care support workers following the birth of their baby.

[1] https://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 Organisation (WHO) and Unicef.

We were told that parent craft classes were held at the unit. These included demonstration classes to show patients how to bath and bottle feed their baby.

Improvement needed

The health board must ensure that a range of health promotion information is available for patients where this can be easily seen, including smoking cessation information.

Dignified care

As referred to earlier, during the time of inspection, there were very few patients at the unit. However, we observed staff speaking to patients and visitors who were present in a polite and friendly manner. Comments from patients were displayed on the stairwell within the main entrance to the unit. Patients were highly complementary of the care provided. All patients who completed questionnaires agreed that staff were always polite and listened to them and to their friends and family.

The environment ensured that care was able to be provided in a dignified way. The unit had three birth rooms and each had their own private bathroom facilities. All of the birth rooms were decorated in a homely way and one had a birthing pool. Medical equipment was stored behind blinds to make the rooms feel less clinical and more homely.

All birthing rooms within the unit were private, meaning that birthing partners or other family members could be present before, during and after giving birth. We were told by midwives that patients were encouraged to go home within six hours of giving birth.

We saw that doors were closed during antenatal appointments to ensure the privacy and dignity of patients and their partners were maintained.

We were told that the unit cares for patients who are considered low risk. Patients would be transferred to an obstetric unit, should there be any indication of risk to either mother or baby.

Specialist support was available to the unit from a bereavement midwife. Their role is to provide support to women who suffer loss in pregnancy and refer patients to bereavement counsellors.

All patients who completed questionnaires agreed midwives had asked how they were feeling and coping emotionally in the antenatal period. Most respondents also agreed midwives had talked to them about the emotional changes they may experience after giving birth.

Patient information

We found that directions to the unit were clearly displayed throughout the hospital, meaning that patients were able to find their way easily.

Information within the unit was predominantly available in English with limited information in Welsh.

Staff we spoke with were aware of the translation services within the health board and how they could access these to support patients whose first language may not be English. Welsh speaking midwives were also available. All patients who completed questionnaires said they were offered the option to communicate with staff in the language of their choice.

Staff advised us that they encouraged patients to attend their booking appointments at the unit. This enabled patients to have an overview of the facilities and services available at the unit, and help patients make informed decisions about their care and place of birth.

On 2 December 2019, a new service model was introduced at the unit. This meant there was no longer a midwife present at the unit 24 hours a day, seven days a week. The unit is utilised by community midwives for antenatal and postnatal care service provisions from Monday to Friday between 9am and 5pm. Community Midwives are on-call outside normal working hours to support patients in labour who choose to have their baby at the unit and are called to attend the unit when required. We reviewed a leaflet which is provided to patients to inform them how to access services at the unit, either when they need to contact their community midwifery team, or when they go into labour. This ensured that patients were well informed of the changes and enabled them to access a midwife when required.

We reviewed a birth place decision leaflet which provided information for patients and their partners on planning where to give birth within the health board area. The leaflet includes reference to the provision of a dedicated ambulance vehicle (DAV) in the event that a patient requires emergency transfer from the unit to an obstetric unit. We considered the word ‘dedicated’ could be misleading to patients as they could believe the DAV to be solely for the use of emergency transfers from the unit. However, the DAV is also available for transfers of paediatric, obstetrics and gynaecology patients. In the event that the DAV was unavailable,

transfer would be by emergency 999 call to the Welsh Ambulance Service Trust (WAST). We advised that the leaflet should clearly reflect these arrangements to ensure patients have a full understanding of the services available and enable them to make an informed decision about their birth place choice.

Improvement needed

The health board must ensure that information throughout the unit is made available bilingually.

Communicating effectively

We observed conversations between staff and patients visiting the unit. We found staff to be welcoming and knowledgeable in their conversations with patients.

We looked at a sample of patient records and found there to be clear birth plans documented within them. We also saw evidence of clear discussions of risk assessments in identifying whether patients were low risk and suitable for giving birth at the unit. This included those patients who may normally sit outside of the normal labour pathway but wanted to have their baby at the unit. We saw an example within the sample of patient's records of a patient whose Body Mass Index (BMI)[2] was above what was determined to be within normal ranges, and discussions were held with them to provide relevant information to help them make an informed decision. We saw they had been appropriately risk assessed for suitability for birthing within the unit. We were assured that the process of risk assessing patients was a positive reflection on the low number of patients transferred out of the unit to an obstetric unit.

We were also advised that there is a Facebook social media page which has been created to allow for communication with new mothers and sharing of experiences and feedback.

[2] A measure that uses height and weight to work out if an individual's weight is healthy

Timely care

We saw a clear process in place for patients who go into labour to ensure that a community midwife is called either to attend the patient's home address, or to meet them at the unit, depending on their birth choice. As described earlier, a new service model had been recently introduced at the time of our inspection. We were told that there had been one baby delivered at the unit overnight and there had been no delays reported in arranging for a midwife to attend. Senior managers told us that the new service model would be regularly reviewed to ensure the continuing provision of timely care to patients.

As highlighted earlier, processes were in place to help ensure that patient transfers to an obstetric unit happen in a timely manner. In the event that an emergency transfer is required, the DAV is used when available, or transfer is made by placing an emergency call to the Welsh Ambulance Service Trust (WAST). We reviewed documentation within the unit detailing transfer times from the unit to the obstetric unit. We were assured that transfers were being undertaken in a timely manner.

We spoke to staff in relation to the DAV. They told us, on occasion, the DAV had been used to respond to calls that fell outside of the agreement between WAST and the health board. This meant that the DAV would have been unavailable to the unit if required for emergency transfers. We recommended that the health board should consider whether the DAV is being utilised appropriately in line with the agreement.

Improvement needed

The health board must consider the impact of arrangements to transfer patients without delay, to include whether the DAV is being utilised appropriately and within the agreement between WAST and the health board.

Individual care

Planning care to promote independence

The unit was on the first floor of the hospital and was accessible via steps leading up to the reception area. Lift access was also available through the main hospital.

The environment was clean, spacious and easy to navigate throughout with wide corridors and large, uncluttered birthing rooms.

We saw in the sample of patient records we reviewed that discussions took place with patients at their 36 week ante-natal appointments around their discharge from the unit within six hours of giving birth. This would ensure that patients were fully aware that their stay at the unit was limited. Staff told us that following their discharge from the unit, additional support is available from community midwives in the patient's home.

People's rights

We were told that, to promote the birth options available to patients and provide information to help them make an informed decision, discussions take place in initial booking appointments and throughout the pregnancy. This was also evidenced in the sample of patient's records we reviewed.

Staff told us that patients were allowed to have a partner/carer with them during the birth. All of the birthing rooms were well equipped to support individual choice and to meet the patients' birth choices. One birthing room had a plumbed in birthing pool which allowed patients to use the pool during labour.

Listening and learning from feedback

Staff and managers told us that they would aim to deal with any complaints at source, with a view to resolving them quickly. Bilingual leaflets were displayed in the reception area within the unit relating to the NHS Putting Things Right[3] procedure for patients to follow should they have concerns about their care.

A poster providing details of the Community Health Council[4] (CHC) was displayed on the back of the main exit door. The CHC can provide advocacy and support to patients in raising a concern about their care.

---

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

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

Information from the Patient Advice and Liaison Service (PALS) team was also available. Their role is to ensure there is an emphasis on obtaining views on the care and services provided. We saw that patient feedback was sought through feedback cards which were available on the reception desk. Completed cards were displayed on the stairwell leading up to the entrance of the unit and contained messages of gratitude from patients about the care and support received from staff.

We also distributed questionnaires to staff at the unit to find out what the working conditions are like and to obtain their views on the standard of care. We also received responses to the questionnaire from our online survey. We received eleven completed questionnaires.

Around half of staff who completed questionnaires said the unit collected patient feedback, though a majority said they did not receive updates on feedback. One third of respondents agreed patient feedback was used to make decisions within their department.

Our inspection took place during the first week of the service implementing its new service model. It was therefore too soon for any patient feedback providing feedback on the new model to have been received. Senior managers assured us that all feedback would be regularly reviewed and patient views considered.

Improvement needed

The health board must consider how to feedback from patients can be shared with staff to aid learning and service improvement.

Delivery of safe and effective care

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

Checks of controlled drugs and fridge temperatures were not maintained in line with policy at all times.

We were not assured that birthing pool evacuation training had been carried out by all required staff.

There was early recognition of patients who required transfer to the obstetric unit.

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

Safe care

Managing risk and promoting health and safety

We found the unit to be uncluttered, clean, tidy and free from hazards. All areas within the unit were well-maintained.

We found there were appropriate arrangements to ensure that babies were secure on the wards.

We considered the safety of women using the birthing pool and could not be assured that pool evacuation training had been carried out by all required staff. This meant there was a risk in the event of a patient collapsing, becoming unwell or in an emergency that staff may not have received the relevant training to ensure the safety of patients when using the birthing pool. We are disappointed that this issue has also been highlighted during two previous HIW inspections at maternity units within the health board. We were assured by senior managers that a training programme had been commenced within the health board and relevant staff at the unit would soon receive training. This was also confirmed by the health board in improvement plans provided to HIW following the two previous inspections. This will be followed up by HIW to ensure that staff have received the appropriate training. Staff also told us that the training will be provided to newly employed midwives as part of their induction process and will form part of midwives annual mandatory training.

Preventing pressure and tissue damage

We considered whether pressure risk assessments were being completed for patients when appropriate. We were told by staff that, whilst this is not current practice, a skin care bundle to include pressure ulcer care is being introduced within the new patient record documents. Further details of this is referred to within the 'record keeping' section of this report.

Infection prevention and control

The inspection team saw that all of the areas within the unit were well organised, free from clutter and clean and tidy. All patients who completed questionnaires agreed that the ward was clean and tidy.

Personal protective equipment (PPE) was available in all areas. We were not able to observe the use of PPE during this inspection as there were no patients on the unit. We observed all staff adhering to the standards of being Bare Below the Elbow [5] and saw good hygiene techniques being used. Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow. Hand hygiene gels were available throughout the unit. We also saw evidence of regular hand hygiene audits taking place with high compliance rates.

We saw that monthly spot check audits were carried out within the unit to ensure the environment upheld infection control standards. However, we found there were inconsistencies in the frequency in which they had been completed. Staff described a new process which had been introduced since the implementation of the new service model within the unit. This will ensure that audits would be consistently undertaken on a monthly basis to uphold infection control standards. We saw high compliance with infection prevention and control training undertaken by staff.

There were robust cleaning processes in place for the birthing pool which included when the pool had not been used. This ensured that the birthing pool

[5] 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.

was appropriately cleaned and safe to use. We saw records to show that the birthing pool was cleaned daily.

Nutrition and hydration

During our inspection we considered how patients' nutritional needs were being met throughout the day and night.

Staff told us that hot food is available at meal times from the hospital's catering services and patients are able to choose what they want to eat. There is a also a stock of cold snacks readily available for patients.

We also saw there was a small kitchen for the use of patients and their partners, allowing them the choice of making snacks and hot drinks when required. Tea and coffee making facilities were also available within the birthing rooms.

Medicines management

We looked at the arrangements for the storage and administration of medicines within the unit. We saw that the door to the storeroom that contained controlled medicines was unlocked on one occasion during the first day of the inspection. Whilst the medication cupboards within the storeroom were locked, we saw that medicines were also contained within an unlocked fridge and fluids were easily accessible on a trolley within the room. This could pose a potential risk to the safety of patients and visitors due to the potential of unauthorised access to medicines. This was raised at the time of the inspection and was rectified immediately, with the door being locked. We were assured by staff that it would remain locked and could only be accessed with a key.

We looked at the arrangements for the storage and administration of medicines within the unit. We found inconsistencies across the unit on the daily checks of the fridge temperature at which medication was stored. This meant we could not be assured that any discrepancies in temperatures were being identified and escalated. We also noted that there were inconsistencies in the daily checking of the controlled drugs within the unit. Our concerns regarding the above issue was dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The health board must ensure that the door to the storeroom containing controlled medicines remains locked on an ongoing basis to prevent unauthorised access.

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 who completed a questionnaire confirmed that they had received mandatory safeguarding training within the past 12 months.

We saw the health board had recently introduced a safeguarding maternity database. This allowed all staff to obtain easy access to records of patients who may be at risk with safeguarding concerns across the health board. It also enabled midwives to update records patient records where necessary.

We also saw good evidence of good practice within the sample of patient records we reviewed. Safeguarding issues had been escalated and reported through the appropriate channels.

Medical devices, equipment and diagnostic systems

The inspection team considered the arrangements for the checking of emergency equipment throughout the unit. We found that checks of equipment used in a patient emergency were insufficient as they were not recorded as being carried out on a daily basis. We found this in relation to neo-natal resuscitaires and emergency resuscitation equipment located within a birthing room and in an office room located within the unit. We raised this immediately with representatives of the senior management team who confirmed these checks should be carried out daily. Our concerns regarding the above issue was dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

We found there to be sufficient supplies of relevant equipment around the birth centre and staff reported that there were no issues. Equipment was stored safely and securely in the unit, preventing unnecessary equipment being left around as hazards.

Effective care

Safe and clinically effective care

As previously referred to in this report, the service model for the unit changed on 2 December 2019. Senior managers told us the benefits to the new service model were an increase in community midwifery resources and improved continuity of

care for patients. Given the low number of births at the unit, we considered the change to be a better and more effective use of staff time.

We saw within the sample of patient records we reviewed evidence of early recognition of patients who required transfer to the obstetric unit. We saw that transfers were arranged quickly and that transfer times were reasonable.

All patients told us that a midwife stayed with them during labour and felt that the pain relief received during labour was adequate. All respondents agreed they and their partner received enough support from staff to help them work with the pain of labour. We also saw evidence of appropriate pain relief being provided in a timely manner in the sample of patient records we reviewed.

Quality improvement, research and innovation

We saw good initiatives developed by the consultant midwife with the introduction of birth choice clinics. These provided women with an opportunity to explore their birth choices and provide them with information in a balanced, understandable and individualised way.

The unit currently has access to a mental health nurse to provide support for perinatal mental health. We were told that measures were also underway to recruit a perinatal mental health midwife for the benefit of the maternity units across the health board. This would provide mental health support to patients during the pregnancy, labour, birth and the postnatal period. We also saw evidence of patients being appropriately referred to the mental health nurse within the sample of patient records we reviewed. Patients are invited to attend appointments with the perinatal health nurse within a dedicated room located outside the unit within the hospital.

Information governance and communications technology

Patient information was securely managed and stored within the unit to uphold patient confidentiality and to prevent unauthorised access. Patient records were securely contained within locked cabinets.

The internal intranet was informative with a range of accessible midwifery and medical clinical policies and guidelines for staff. However, some of this information was found to be out of date and in need of review. We spoke to senior managers who said that all policies and guidelines were currently under review and the process would be completed by the end of December 2019.

Record keeping

We considered a sample of patient records within the unit. Overall, we found patient records were being maintained to a good standard. We found them easy to navigate, clear to follow and written contemporaneously.

We saw good evidence of discussions held regarding patients birth choices being documented. Information included the risks and benefits of their birth choices.

Within the sample of patient records we reviewed, we saw very strict criteria was applied in terms of risk assessments to identify patients who were considered to be low risk and appropriate to give birth at the unit. As a result, we saw that this had a positive impact on the low number of patients who were transferred to an obstetric unit.

We saw that the health board had recently introduced new patient maternity booklets, which inlcuded separate booklets for antental inpatient record, skin care bundle, induction of labour and postnatal care.

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.

We found the service had in place a number of regular meetings to improve services and strengthen governance arrangements.

A monthly maternity risk management newsletter is produced which is a good communication tool in conveying information to staff across the maternity units across the health board.

We found improvements could be made with regards to communication with staff to improve staff morale.

Governance, leadership and accountability

We saw that the health board had a dedicated lead midwife for clinical risk and governance in place. They had responsibility for reviewing, investigating and managing clinical incidents across all three of the maternity units within the health board area. Information relating to clinical incidents, investigations and their findings were shared at a range of meetings. This included risk management meetings, labour ward forums and monthly quality safety and patient experience meetings. In addition, weekly management meetings and midwife band 7 meetings took place.

A monthly maternity risk management newsletter was produced which included key findings from the investigations and reviews undertaken and communicated any themes and trends to staff. Staff told us that themes and trends were also discussed at community team meetings. Information was shared across the health board, and not specific to the unit, meaning that staff had the opportunity to learn from different settings. Senior managers told us that the newsletter was available to staff on notice boards and circulated by email to all staff by team leaders.

We saw that an additional edition of the maternity risk management newsletter had been produced following an earlier inspection by HIW of another maternity unit within the health board. We were pleased to see the findings of the HIW

inspection had been promptly shared with staff within all maternity units across the health board to highlight some of the areas of improvement identified during the inspection. Whilst this is positive, as referenced earlier in the report, we were disappointed that the same immediate improvement issues were identified during this inspection as in previous HIW inspections.

The unit was using a maternity dashboard which is an electronic tool to monitor the clinical performance and governance of their services. We were assured that there was a good level of oversight of clinical activities and patient outcomes. The dashboard provided information with regard to clinical activity on the unit, which included the number and category of births (vaginal, caesarean section, assisted), number of homebirths, and also clinical indicators such as intensive care admissions, blood transfusions, neonatal admissions and neonatal morbidity. The dashboard was rated red, amber and green depending upon the level of risk associated with the numbers and figures. It was updated monthly and discussed at the labour ward forum and the quality, safety and patient experience meetings. Information from the dashboard was also shared to staff via the monthly risk management newsletter.

We spoke to staff who described the process for reporting incidents on the health board's incident recording system. Staff said they felt encouraged and supported to report serious incidents, however some said they do not always get feedback on lessons learnt afterwards. The majority of staff who completed questionnaires agreed the organisation encouraged staff to report incidents and near misses. Around half of respondents agreed the organisation treats such reports confidentially. About a quarter of respondents said the organisation does blame or punish people who are involved in errors or near misses. Given these comments from staff, the health board needs to consider the issues raised in this area.

Improvement needed

The health board must consider the culture and learning around incidents, including ensuring that learning is shared with all staff in an open, non-punitive environment.

Staff and resources

Workforce

We spoke to staff within the unit who provided their views on the implementation of the new service model. Overall, staff we spoke to expressed negative views and were unhappy with the change. Some staff told us the decision to make the change had been prior to any staff consultation taking place and they did not feel their views had been considered. One member of staff also commented that the new service model would have a negative impact on their work life balance. However, another member of staff told us that the change was inevitable due to the low number of births at the unit whist remaining staffed by a midwife 24 hours a day. They felt that the change was a good opportunity for midwives to put effort into maximising the footfall of women in the unit, and increasing the birth rate. Senior managers told us that a formal staff consultation process had taken place in line with the NHS organisational change policy. We reviewed documentation which confirmed this. However, in light of the concerns expressed by staff, we recommended that senior management continue to engage with staff around this issue to improve staff morale.

We received somewhat mixed feedback from staff who completed our questionnaires regarding communication with senior management. One third of staff said that communication between senior management and staff were effective and a third said it was not. Half of respondents said their manager always or usually encouraged them to work as a team and one said they never did.

Senior managers confirmed explained how the unit was compliant with birth rate plus[6] and the new service model was operating with a higher number of midwives on duty or on-call than recommended. The majority of staff we spoke to said that four on-call midwives at night was sufficient, however one member of staff did not think it was. Senior managers explained that it was too early to assess whether staffing levels were appropriate for the new service model and this would be monitored and assessed on an ongoing basis.

[6] Birth-rate Plus is a midwife planning tool that provides a comprehensive assessment of the staffing needed to provide the care required by a woman in maternity services.

The inspection team reviewed the individual training portfolio documents which were issued to midwives. These documented the mandatory training required of them, as well as signposting additional learning that was available. Three mandatory maternity related study days are held by the service across the year. One of the days is Practical Obstetric Multi-Professional Training (PROMPT) training, which is a multidisciplinary training event used to encourage multidisciplinary working in emergency situations. We reviewed the content of folders in each of the birthing rooms which contained PROMPT guidance for use of midwives in the event of an emergency situation during a birth. Whilst we considered the content of the guidance to be of a high standard, it was generic to obstetric care. We recommended the content of the folders could be streamlined specifically for care within the unit.

We spoke to the health board's practice development midwide who told us that a bespoke half day training session on emergencies will be provided for the community midwifery team. The training will include how to manage emergencies within the unit and in a community setting.

Other mandatory study days included fire safety training, adult safeguarding, maternal basic life support and newborn resuscitation amongst other topics. In addition, we saw that staff were required to complete mandatory e-learning which included infection prevention and control and safeguarding.

We were shown compliance figures for mandatory training and were assured that regular training was taking place. Compliance was 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. All staff who completed a questionnaire answered that training has always or usually helped them do their job more effectively and nearly all said it helped them to deliver better patient experience. All said training had helped them to stay up to date with professional requirements. However, one member of staff told us they did not have time to complete the e-learning training in work and had to complete it in their own time.

We were told by senior managers that, prior to the new service model being introduced, staff were provided with a training needs analysis document to complete. This provided midwives with an opportunity to highlight any additional training they required to support them during the transition from working within the unit to being based within a community setting and ensure a safe quality service. We also saw documentation which supported the offer of additional training. One staff member we spoke to said the they had not been asked for any training needs to help with the transition and change in staff role.

Most staff who completed a questionnaire said they had received an appraisal in the last 12 months and around half said their training needs were identified. Around half of respondents said their manager had supported them to receive training.

Improvement needed

The health board must:

- Consider the effectiveness of communication with staff including around the service change and how to address staff morale.
- Ensure the content of the PROMPT guidance folders are tailored specifically for care within the unit and that future PROMPT training is aligned to the new service.

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 were identified on this inspection			

Appendix B – Immediate improvement plan

Hospital: Withybush Hospital, Hywel Dda University Health Board

Ward/department: Midwifery Led Unit

Date of inspection: 3 & 4 December 2019

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action it will take to: Ensure that checks of the neo-natal resuscitaires and emergency resuscitation equipment are carried out and recorded on a daily basis and in line with their policy.	2.1 Managing Risk and Promoting Health and Safety	Community Operational Lead Midwife to receive weekly assurance audits from community managers to monitor compliance of equipment checking.	Head of Midwifery & Women's Services	December 2019 - Completed
	2.9 Medical Devices, Equipment and Diagnostic Systems	Consultant Midwife to conduct monthly assurance audit to provide external scrutiny.	Consultant Midwife	December 2019 - Completed
		All staff to be reminded regarding importance and requirements for consistent checking of equipment via	Head of Midwifery &	December 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
Medicines are stored at appropriate temperatures and regular checks of medicine fridge temperatures are maintained in line with the health board's policy.	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	communication file, Clinical Risk Newsletter and via staff meetings and forums. From 2nd December 2019 the Midwifery Led Unit at Withybush General Hospital is not manned 24/7 • Daily checks of fridge temperature to be recorded Monday to Friday on specific Performa. • Locked medicine fridge to be kept within a locked room away from patient's access Medicines and Medicine fridge temperature to be managed in line with the HDUHB Medicine Management Policy and Patient Safety Standards for a un- manned Midwifery Led Unit.	Women's services Head of Midwifery & Women Services Head of Midwifery & Women Services Head of Midwifery & Women Services	Completed Completed Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		• Fridge temperature to be recorded on a specific Performa by community midwives utilising the MLU.	Head of Midwifery & Women Services	Completed
		• Medicine Management Policy to be circulated to all midwifery staff via NHS Wales emails.	Head of Midwifery & Women Services	Completed
Checks of controlled drugs are maintained in line with policy at all times.	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	Actions identified All relevant staff to be made aware of the importance of complying with medicine management policy in relation to Checks of controlled drugs. Communication to be via 'Hot File' and Risk Newsletter.	Head of Midwifery & Women Services Head of Midwifery & Women Services	Completed Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Medicine Management Policy and Standard Operating Policy for the MLU to be circulated to all midwifery staff via NHS Wales emails.	Head of Midwifery & Women Services	Completed
		Following actions taken relating to storage of controlled drugs for an unmanned MLU:	Head of Midwifery & Women Services	Completed
		- MLU securely locked freestanding unit with 24hour CCTV surveillance.	Head of Midwifery & Women Services	Completed
		- **Action in place**-		
		- Restricted entry to the MLU	Head of Midwifery & Women Services	Completed
		Controlled drugs are stored within a locked room and locked medicine cupboard in line with HDUHB Medicine Management policy and MLU Standard Operating Process.	Head of Midwifery & Women Services	Completed

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		- Process in place for daily checking of controlled drugs Monday to Friday.	Head of Midwifery & Women Services	Completed
		- Controlled drug keys stored within a digital key safe.	Head of Midwifery & Women Services	Completed
		Conduct monthly assurance audit to provide external scrutiny.	Head of Midwifery & Women Services	Completed

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): Julie Jenkins

Job role: Head of Midwifery & Women's Services

Date: 10 December 2019 and 15 January 2020

Appendix C – Improvement plan

Hospital: Withybush Hospital

Ward/department: Midwifery Led Unit

Date of inspection: 3 & 4 December 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 a range of health promotion information is available for patients where this can be easily seen, including smoking cessation information.	1.1 Health promotion, protection and improvement	Information posters including smoking cessation to be displayed in the Midwifery Led Unit.	Head of Midwifery	9 January 2020 Completed
The health board must ensure that information throughout the unit is made available bilingually.	4.2 Patient Information	Audit to be undertaken to benchmark what bilingual information is available. Work in partnership with translation services to provide bilingual information.	Head of Midwifery Head of Midwifery	31 March 2020 31 March 2020
The health board must consider the impact of arrangements to transfer patients without delay, to include whether the DAV is being utilised	5.1 Timely access	Monitored via DATIX reporting system.	Head of Midwifery	9 January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
appropriately and within the agreement between WAST and the health board.		Working SOP in place outlining parameters for antenatal, in-utero, and postnatal transfers of care.	Head of Midwifery	Completed 9 January 2020 Completed
The health board must consider how to feedback from patients can be shared with staff to aid learning and service improvement.	6.3 Listening and Learning from feedback	Patients story to be shared at monthly MLU staff meetings, in the Maternity Risk Newsletter and at Labour Ward forum and Directorate meetings.	Head of Midwifery	9 January 2020 Completed
Delivery of safe and effective care				
The health board must ensure that the door to the storeroom containing controlled medicines remains locked on an ongoing basis to prevent unauthorised access.	2.6 Medicines Management	From 2 December 2019 the Midwifery Led Unit at Withybush General Hospital is not manned 24/7 Staff to be reminded regarding importance and requirements for compliance to medicines management controlled drugs policy via 'Hot File' and Risk Newsletter. Actions implemented for an unmanned MLU:	Head of Midwifery	2 December 2019 Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MLU is securely locked freestanding unit with 24 hour CCTV surveillance.	Head of Midwifery	2 December 2019 Completed
		Restricted entry to the MLU.	Head of Midwifery	2 December 2019 Completed
		Controlled drugs are stored within a locked room and locked medicine cupboard and are stored within a digital key safe in line with HDUHB Medicine Management policy and MLU Standard Operating Process.	Head of Midwifery	2 December 2019 Completed
		Process in place for daily checking of controlled drugs Monday to Friday on a specific proforma.	Head of Midwifery	2 December 2019 Completed
		Medicine Management Policy and Standard Operating Policy for the MLU circulated to all midwifery staff via NHS Wales emails.	Head of Midwifery	2 December 2019 Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Monthly assurance audit to provide external scrutiny.	Head of Midwifery	2 December 2019 Completed
Quality of management and leadership				
The health board must consider the culture and learning around incidents, including ensuring that learning is shared with all staff in an open, non-punitive environment.	Governance, Leadership and Accountability	Lessons learnt are shared via Clinical Risk Newsletter, Labour ward forum, table top discussions and learning events held with the multidisciplinary team.	Head of Midwifery	2 December 2019 Completed
The health board must consider the effectiveness of communication with staff including around the service change and how to address staff morale. The health board must ensure the content of the PROMPT guidance folders are tailored specifically for care within the unit and that future PROMPT training is aligned to the new service.	7.1 Workforce	NHS staff survey to be distributed to all staff 01/03/20 to ascertain staff morale following organisational change. All staff attend PROMPT training as integral part of Mandatory and Statutory training annually. HDUHB piloting the community PROMPT training which commenced January 2020 and is appertaining to community model of care incorporating MLU facilities.	Head of Midwifery Head of Midwifery Head of Midwifery	31 March 2020 2 December 2019 completed 2 January 2020 Completed

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): **Julie Jenkins**

Job role: **Head of Midwifery**

Date: **28 January 2020**