Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Ysbyty Gwynedd – Maternity Services, Betsi Cadwaladr University Health Board

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Contents

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 maternity services at Ysbyty Gwynedd within Betsi Cadwaladr University Health Board on 25, 26 and 27 November 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:

- Llifon ward - antenatal ward (before delivery) and postnatal ward (following delivery) with a capacity of 28 beds
- Midwifery led unit - with a capacity of two delivery rooms and one birthing pool
- Labour ward - (during labour) with a capacity of seven delivery rooms and one birthing pool
- Triage assessment area and a waiting room
- One operating theatres.

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 were positive about the care and treatment provided during their time in the unit
- We observed professional, kind and dignified interactions between staff and patients
- There was a good range of health promotion information displayed
- There were good arrangements in place to provide women and families with bereavement support
- Good governance of daily clinical activities
- Strong midwifery and medical leadership was evident and there was good support offered to staff.

This is what we recommend the service could improve:

- Review of medical job plans
- Review of policies and procedures
- Some areas of patient record keeping
- Review of access to perinatal mental health support.

3. What we found

Background of the service

Betsi Cadwaladr University Health Board is the largest health organisation in Wales, providing a full range of primary, community, mental health and acute hospital services for a population of around 678,000 people across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, and Wrexham). The health board has a workforce of approximately 16,500 staff.

There are three main hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Wrexham Maelor Hospital), along with a network of community hospitals, health centres, clinics, mental health units and community based teams.

Ysbyty Gwynedd is the district general hospital for the west area of North Wales, situated in Bangor. The hospital serves a population of over 200,000 people. The acute hospital service has a total of 684 beds, with a full range of specialties.

Maternity services are managed as a North Wales networked service supported by a neonatal network. 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 6,224 births per year, with around 1,770 of these at Ysbyty Gwynedd.

Women who birth within the health board have the choice of four birth settings. These include home, freestanding midwifery led units, alongside midwifery led units and obstetric units.

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 told us they had always been treated with dignity and respect.

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

We found perinatal resource required review to increase support availability.

Health promotion was clearly displayed throughout the unit.

We identified improvements regarding birth choices discussed and appropriate documentation.

During the inspection, we distributed HIW questionnaires to patients, families and carers to obtain their views on the standard of care provided. A total of 10 questionnaires were completed. We also spoke with 10 patients during the inspection.

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

> *"Help always available – baby taken away overnight so that I could get some sleep".*
>
> *"Staff approachable and always felt welcome".*

The majority of the patients confirmed their postnatal stay had been more than 24 hours.

Staying healthy

We found there were good amounts of health promotion information displayed in relation to breastfeeding, skin to skin advice, post-natal mental health and general advice on keeping healthy before, during and after pregnancy.

The hospital was a designated no smoking zone, which extended to the use of vapour/e-cigarettes, we saw information in relation to smoking cessation throughout the unit.

Dignified care

During the course of our inspection, we witnessed many examples of staff being compassionate, kind and friendly to patients and their families. We saw staff treating patients with respect, courtesy and politeness at all times. The majority of patients who completed our questionnaires were very positive about their experience of care.

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

There were en-suite facilities within some of the birthing and postnatal rooms to help support dignity during the patient's stay. Where en-suites facilities were not available, shared toilet facilities were located nearby.

Four of the patients who completed questionnaires, said they saw the same midwife in the birthing unit as they did at their antenatal appointments. Half of the patients were six to 12 weeks pregnant when they had their booking appointment. All patients said they were asked by the midwife about how they were feeling and coping emotionally in the antenatal period.

All of the staff we spoke with said they had received bereavement training and would feel confident in accessing the correct policies and support, to enable them to appropriately care for any recently bereaved parents. There was a dedicated bereavement room within the unit, known as the 'Angel Suite'. We saw this provided a comfortable environment for patients and families to use. If this room was in use, we were told that an unoccupied postnatal room would be made suitably available. However, we felt that its location, adjacent to the assessment unit was not suitable due to sound and visibility of expectant mothers being assessed from the doorway. There had been sound proofing measures put in place to reduce outside sound and there were also plans seen in redesigning the room to maintain dignity and respect of patients and families. We were told that plans had been recently approved but had not yet progressed at the time of our

visit. We were told that a bereavement lead who worked across the three sites within the health board was available through core working hours to offer support and advice. Staff also told us that the on-call matron for the maternity service would be the first point of contact if guidance was required outside of core hours. However, staff also said they felt there was a lack of perinatal support for patients due to the limited resources of the dedicated mental health team which some senior staff also confirmed to be a concern.

Improvement needed

The health board must ensure that resource and availability of perinatal support is reviewed.

Patient information

We found that directions to the maternity unit were clearly displayed throughout the hospital. This made it easily accessible for people to locate the appropriate place to attend for care. Visiting times were clearly displayed within the unit and staff told us there would be flexibility around this if requested.

Daily staffing details were displayed within in the unit to inform patients of who would be caring for them.

Information was available in both English and Welsh and staff we spoke with were aware of the translation services within the health board and how to access these. Welsh speaking midwives were also identifiable by the Welsh speaker logo[2] 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 said they felt

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

confident to ask for help or advice when required. The majority of patients also said they had been listened to by midwifery and medical staff during their stay. However, the majority of patients we spoke to and those who had completed questionnaires said they were not always spoken to regarding their birth choices. There was also little evidence of discussions around this seen within the case notes we reviewed.

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 when providing care to protect patients' privacy and dignity.

We saw that staff within the unit met twice daily, at shift change-over time. Midwifery and medical handovers were held separately due to midwifery and medical shifts not following the same working pattern. The handover meetings we were able to attend, displayed effective communication in discussing patient needs and plans with the intention of maintaining continuity of care. These meetings were well-structured and evidence based which the inspection team felt to be of noteworthy practice.

Each ward had a patient safety at a glance board[3] which was used on a daily basis by multidisciplinary teams. These boards clearly communicated patient safety issues and daily care requirements or plans, as well as individual support required and discharge arrangements.

We were also told by staff that active learning was seen through vibrant maternity voices[4] and birth afterthoughts groups [5], which are chaired by a service users. They had been created for mums-to-be and new mums to meet and discuss

[3] The Patient Status at a Glance Board (PSAG) is used in hospital wards for displaying important patient information such as; the infection risk levels, mobility, admission and discharge flow, occupied number of beds, nursing and medical teams, amongst others.

[4] Vibrant Maternity Voices – User engagement group which holds engagement events with a key focus on encouraging normality – ensuring that women's voices are heard.

[5] Birth Afterthoughts is a listening service, co-ordinated by the consultant midwife, available to any women and their partner who have give birth in BCUHB. It is confidential and provides an opportunity to discuss and understand what happened during labour and birth.

services, care and improvements. There was also a Facebook page seen for anyone wishing to learn more regarding maternity services within North Wales.

Improvement needed

The health board must ensure that discussions regarding birth choices take place and are documented accordingly.

Timely care

The patients we spoke with told us that staff were very helpful and would always attend to their needs in a timely manner. Staff explained they would always ensure that patients are regularly checked for personal, nutritional and comfort needs. This was also seen within the patient's records we reviewed. We also saw that call bells were easily accessible and answered in a timely manner.

We saw that patient observations were recorded on 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, which enabled appropriate and timely action to be taken.

Individual care

Planning care to promote independence

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

We looked at a sample of patient records within the unit and found evidence that patient's personal beliefs and religious choices were captured during antenatal appointments. This was to help ensure they were upheld throughout their pregnancy, labour and postnatal care. We saw that care plans also promoted people's independence based on their assessed abilities.

Birthing partner support was promoted and all of the birthing rooms were well equipped. Two of the birthing rooms within the unit also had a plumbed in birthing pool which patients could use during labour.

We were told by staff and patients that local parent craft groups such as breastfeeding and health promotion before and after delivery, were very beneficial for new mothers and fathers. Parent classes were also offered to families in their own homes. These sessions are organised and delivered by midwifery support workers and were seen by the inspection team to be good practice in promoting independence.

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 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 between 9.00am and 8.00pm. Staff also told us that birthing partners could stay with the patient during labour.

The hospital provided a chaplaincy service and there was a hospital chapel. We were also told about arrangements to enable patients from different faiths to access the prayer rooms to meet their spiritual needs.

Listening and learning from feedback

Information was available on the health board's website relating to the process for patients to follow should they have concerns they wish to raise, there was also information available on the unit. We were told by the senior management team that ward managers within the unit were fully aware of the NHS Wales Putting Things Right[6] process and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints. However, staff did not routinely provide patients with details of the Community Health Council (CHC)[7] who could provide advocacy and support to raise a concern about their care.

We were told that following an informal complaint, lead matrons would contact a patient offering to discuss their issues, as well as promoting the formal complaint procedure should they wish to follow this route. Staff explained that this was used as a way of addressing concerns, but also with a view to highlight any practice issues that may need resolving. Staff told us that communication was maintained with patients and families throughout any concern received and they were also given the opportunity to meet with senior members of staff to discuss their concerns further.

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

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

Staff told us that they regularly seek patient feedback through feedback forms or questionnaires, one of which is the birth afterthoughts information card which was given to all women following birth. We were told these are acted upon by the senior management team and shared with staff during lessons learnt meetings and appraisals.

Improvement needed

The health board must ensure that patients and families are made aware of the Community Health Council (CHC) 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.

Overall there were 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 of medicines, pain assessment and clinical incidents, ensuring that information and learning is shared across the service.

We identified areas for improvement regarding breastfeeding support and provision within the unit.

We found patient safety was promoted in daily care planning and this was reinforced within the patient records we reviewed, however inconsistencies in medical record completion was evident.

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

Safe care

Managing risk and promoting health and safety

The unit appeared to be very clean, appropriately lit, well ventilated and clutter free. Clinical rooms such as clean utility and sluice were also seen to be very well organised.

We considered the unit environment and found sufficient security measures in place to ensure that babies were safe and secure within the unit. We noted that access to the birthing unit was restricted by locked doors, which were only accessible with a staff pass or by a member of staff approving entrance. We were also assured that abduction drills and fire drills regularly take place to ensure safety is maintained in an emergency.

We looked at the arrangements within the unit for accessing assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells. 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 resuscitation emergency trolley and we were assured that regular stock, date and maintenance checks were taking place on this equipment.

Emergency evacuation equipment was seen within the birth pool rooms, which could be used in the event of complications during a water birth. We were also assured that all staff had received appropriate training in their appropriate use in the case of emergency.

Falls prevention

We saw there was a risk assessment in place for patients admitted onto the unit and those using birthing pools. We were informed that any patient falls would be reported via the health board's electronic incident recording system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately.

Infection prevention and control

We found that the clinical areas of the unit were clean and we saw that personal protective equipment was available in all areas and was being used by all healthcare professionals.

During the inspection, we observed all staff adhering to the standards of being Bare Below the Elbow[8] and saw good hand hygiene techniques. We found hand washing and drying facilities were available. We also saw information displayed to promote the correct hand washing procedure for staff to follow. However, we saw some hand sanitiser gel dispensers within the unit empty or not working.

We were told that an infection control audit had been carried out by the health board recently and we were shown the results of this. We found that cleaning schedules for the unit were in place and up-to-date and we saw designated labels on equipment to signify that it was clean and ready for use.

[8] 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.

We saw high compliance with infection prevention and control training. Staff explained that any concerns raised regarding infection prevention and control would be escalated to senior members of staff.

Some side rooms within the unit were available for patients use should there be a requirement to reduce the risk of infection and help prevent infections being transferred to other patients.

We were told that the birthing pools were cleaned daily and evidence of this was seen.

Improvement needed

The health board must ensure that hand sanitiser gels are available for use.

Nutrition and hydration

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

Within the unit there were facilities available to purchase drinks if required. We saw patients being offered hot and cold drinks and water jugs were within easy reach. Staff on the unit had access to facilities to make toast and drinks for patients outside of core hours. Patients also told us that the food and drinks available were to a good standard.

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

Medicines management

We looked at the arrangements for the storage and administration of medicines within the unit. We found that medication cupboards were securely locked to maintain safety.

There were daily checks of the temperature at which medication was stored. We found there were suitable arrangements for the safe and secure storage and administration of controlled drugs. We also noted that medication prescribing and administering was in line with the health board policy.

We looked at a sample of medication records and saw these had been completed appropriately. 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.

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 at risk. Safeguarding training was mandatory and all staff we spoke to confirmed they had received training within the past 12 months.

There was an appointed lead safeguarding midwife for the health board who would provide support and training to staff. We were told that safeguarding training included guidance regarding female genital mutilation, 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. Formal safeguarding supervision had been recently introduced and was mandatory for staff to attend two sessions per year. The health board recently started to roll-out the process 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 found the checks on the neo-natal resuscitaire[9] to be consistently recorded demonstrating that they had been carried out on a daily basis.

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

[9] Device to have during labour and delivery procedures, combining an effective warming therapy platform along with the components needed for clinical emergency and resuscitation.

Effective care

Safe and clinically effective care

Staff who we spoke with told us that they were happy with the quality of care they were able to give to their patients. We were told by staff and patients that those in the birthing unit would always be kept comfortable and well cared for, with pain relief available during labour. We also saw good evidence of medical assessment and treatment plans throughout the patient records reviewed. We observed staff effectively prioritising clinical need and patient care within the unit. From the patient records reviewed, it was evident that clinical need prioritisation was forefront in care planning.

The inspection team saw that the midwifery led unit had admission criteria that facilitated birth for low risk women with group B strep or who required induction of labour for a postdates pregnancy, thus encouraging normality. This was seen to be good practice as it promoted birth choice continuation.

We were also told that the unit had dedicated theatre staff coverage from the general theatres in the hospital, for caesarean sections or other surgical procedures. Two operating theatres were seen and midwives we spoke with confirmed that unless they were trained to do so, they were never expected to practice as a scrub nurse[10] and perform scrub duties. They also told us that maternity and theatre staff worked well together as a team.

Although we saw that a breastfeeding coordinator was appointed, staff and senior managers told us that the substantial workload covered meant that visibility on the unit to promote breastfeeding was greatly reduced. The inspection team felt that more support in breastfeeding was needed within the unit.

[10] Scrub nurses are registered nurses who assist in surgical procedures by setting up the room before the operation, working with the surgeon during surgery and preparing the patient for the move to the recovery room.

Improvement needed

The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.

Quality improvement, research and innovation

A lead clinical research and improvement midwife was in place, who covered maternity services across the health board. We were told that projects to support education in growth assessment protocol (GAP) and gestational related optimal weight (GROW)[11], epilepsy in patients, and the full review of documentation and the creation of care pathways across the unit had been recent projects completed. We were told that further work was planned to implement the use of innovation champion midwives across the service, who would be encouraged to become involved in innovation and research projects to support the team.

The health board maternity practice development midwife was also seen to carry out the inspirational work of Practical Obstetric and Multi-Professional Training (PROMPT)[12].

Information governance and communications technology

We found secure measures in place to store patient information to uphold patient confidentiality and to prevent unauthorised access.

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and procedures. However, we found a number were out-of-date and requiring review.

We found that a monthly maternity dashboard was produced which included information in relation to each hospital and across the health board. This provided

[11] GAP – Growth assessment protocol - GROW – Gestation related optimal weight (A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[12] PROMPT - Practical Obstetric and Multi-Professional Training. The course teaches attendees how deal with obstetric emergencies.

information with regards to the clinical activity, induction of labour, clinical indicators and incidents. The dashboard was rated red, amber and green depending upon the level of associated risk.

We saw that data was collated from birth registers manually by two labour ward midwives. However, Welsh Government receive all maternity data via electronic information systems as well as other national bodies when benchmarking outcomes of birth. Maternity data is captured electronically following birth, therefore we suggested that the department consider moving from manual to electronic data collection for greater efficiency.

Improvement needed

The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.

Record keeping

Overall, we found the standard of record keeping to be adequate with care plans well documented between multidisciplinary teams. We saw appropriate observations charts, care pathways and bundles being used. However, whilst we saw that preventative measures had been put in place to prevent venous thromboembolism[13] for patients on the unit, risk assessments had not been documented to support the reason why.

We also saw inconsistencies across the medical health records reviewed with gaps in areas such as medical signatures and General Medical Council registration number completion.

Improvement needed

The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping.

[13] https://www.nice.org.uk/guidance/ng89/chapter/Recommendations#risk-assessment

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 positive regarding the support they received from senior staff.

We however recommended improvements in medical job planning to maintain continuity of care.

Governance, leadership and accountability

We saw a number of regular meetings were held to improve services and strengthen governance arrangements. Such meetings included a monthly maternity quality and safety group, monthly audit review meetings and obstetric clinical review of incident meetings. Additionally, there were monthly ultrasound screening, labour ward, postnatal and neonatal forums and weekly

multidisciplinary meetings such as Cardiotocography (CTG)[14] reviews. We found there was good overall monitoring and governance of the staffing levels of the service.

We also found there was internal audit activity taking place, which was being monitored and presented in appropriate quality, safety and risk meetings and forums. Staff also told us that active learning and follow-up on audit actions were always carried out.

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)[15] and Each Baby Counts[16] 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.

We have seen evidence of a newly formed focus group with an aim of reducing caesarean section rates as well as PPH which is led by a labour ward consultant lead. There is a clear plan in place to review the notes and highlight the good practice and areas of improvements. The clinical director is overseeing this project.

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in place, who held responsibility for reviewing, investigating and managing clinical incidents across the health board. All staff we spoke with told us that the organisation encourages them to report

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[14] Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

[15] 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, new-born and infant health services.

[16] 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.

errors, near misses or incidents and that these were never dealt with in a punitive manner.

Monthly risk meetings are held at Ysbyty Gwynedd 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. We were assured that the internal risk register was monitored and acted upon when required.

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead governance midwife presented themes and trends to this meeting, with the view of highlighting any areas of practice improvements required across the heath board. Lessons learnt are shared and circulated to all staff within a monthly feedback newsletter, summarising the month's issues which staff told us was very useful.

Staff felt the daily leadership within the unit to be excellent. Staff said they felt supported by the senior team and there is always an 'open door' to speak to them. We were also told by staff that the senior team members would hold monthly visits to all sites which gave staff the opportunity to gain feedback and support if required.

We also saw good work carried out by the consultant midwife to achieve expert practice. This included the development of the new Vaginal Birth After Caesarean Section (VBAC)[17] protocol, user engagement in service development, and creation of many training initiatives to increase learning and development.

[17] VBAC - Vaginal Birth After Caesarean Section – Where many women who have had one previous caesarean section can safely have a vaginal birth in a subsequent pregnancy, or they can choose to have a caesarean section.

Staff and resources

Workforce

All staff we spoke with felt they received excellent leadership and support, personally and professionally. Strong team working was seen to be encouraged by all senior managers. This was confirmed by staff we spoke with and those who completed our questionnaires. A number of staff said they considered their working environment to be positive and they were happy to work within Ysbyty Gwynedd. Some of the comments from staff included the following:

"I've been well supported by all staff at Betsi and appreciate this"

"Very supportive, kind and welcoming staff both acute and community".

Senior staff we interviewed shared with us the success of support given to the maternity services from Deloitte Risk Advisory UK[18]. This support mechanism was introduced into the health board four years ago when the health board was placed into special measures[19]. Effective outcomes have been seen in relation to working practices, working relationships and operational risk management.

We were told by all staff that midwifery rotas were managed well within the unit. If there were any shortages of staff cover, the newly introduced midwife on-call system would be used. The system was developed to place midwives (currently working within the acute site) onto a rota to cover staffing shortages, rather than using community midwives. Positive feedback had already been received regarding this change and an increase in homebirths was reported due to community midwives being able to perform community based care instead of being called in to the acute site to cover shortages.

We saw there were departmental escalation processes in place and all staff we spoke with were aware of where to locate the policy and how to escalate issues

[18] Delloite Risk Advisory UK – an organisation who supported the HB to enable business to understand and manage their risks more effectively, allowing them to create and protect their values for all of their stakeholders.

[19] Special measures refer to a range of actions which can be taken to improve health boards, trusts or specific NHS services in exceptional circumstances.

such as staffing shortages. Senior staff also told us that if required, clinically trained office staff would cover shortages where required.

Medical staff we spoke felt medical rotas were being managed well. However, we learned that on occasion some medical staff can be pulled away from the delivery unit to cover workload on the early pregnancy assessment and obstetric emergency unit. This meant the delivery unit would be left with only registrar cover. This was seen to have a detrimental effect on continuity of care. We spoke to the senior medical team and they acknowledged that this was an area for improvement and advised that work plans would be reviewed imminently. The clinical director of the unit confirmed that the job planning of consultant obstetrician and gynaecologists is under review in the view of allocating a nominated dedicated consultant obstetrician to be present on labour ward during working hours. This would maintain continuity of care and improving senior medical cover within the unit.

Some medical staff also felt the service needs to implement the role of a fetal medical consultant within the maternity outpatients, to deliver care to women requiring support in the antenatal period. We were advised that a review of fetal medicine services in North Wales is underway and will be completed mid 2020. Staff also explained that a fetal medicine task and finish group is duly considering the addition of a fetal medicine component in the vacant consultant post.

We saw evidence of robust induction programmes for both midwifery and medical staff and staff felt these were of benefit when commencing their role. We also saw that the training and mentorship arrangements for medical staff was very positive. Medical staff we spoke with confirmed that the training, support and guidance is of a high standard. Medical and midwifery staff also said the organisation encourages and supports good teamwork.

We found 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, infection prevention and control and safeguarding, is predominately completed 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 PROMPT training, which is a multidisciplinary training event used to encourage multidisciplinary working in emergency situations. All staff we spoke with said they attend this training when they can and find it very useful. We were shown compliance figures for PROMPT training and were assured that

regular training was taking place. This was also confirmed in the staff questionnaires received.

The health board had a lead midwife for practice education/practice facilitation who monitor compliance with training across the year. Staff are required to book themselves onto the relevant training days and attendance is reported to the senior teams.

We saw evidence of training in CTG, however staff we spoke to told us that the recently introduced CTG monitoring stickers (method of improving continuity of care) were confusing due to the information required and more training in the completion of theses was required.

Clinical supervisors for midwives were in place across the health board. The supervisors are responsible for ensuring compliance with the national standard that all midwives access four hours of contact with a clinical supervisor for midwives, inclusive of two hours of group supervision. The health board monitor compliance with this target during the previous financial year and are continuing this on an ongoing basis.

We confirmed that within the unit all appraisals were up-to-date. Staff we spoke with told us that they have regular appraisals and they see them as positive meetings to increase continuous professional development. We were also told that continuous professional development and training time is given to all staff within their working hours.

We found there was a good level of support in place from the specialist lead midwives, who were knowledgeable about their specialist roles. These leads provide support and guidance through study days, supervision sessions and meetings with staff, as and when required. We also saw a good range of skill mix throughout the unit.

Although we were told there were no nursery nurses employed within the services, we saw that maternity support workers were encouraged to develop their skills to the next level in qualification. This would mean more support could be given to the midwives and new mothers in areas, such as breastfeeding, bathing and general care needs.

Improvement needed

The health board must ensure that:

- CTG training is reviewed to cover the introduction of new processes e.g. CTG assessment stickers
- Medical work plans are reviewed to ensure adequate medical cover is in place at all times.

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

Service: Ysbyty Gwynedd

Area: Maternity Services

Date of Inspection: 25 – 27 November 2019

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
N/A			

Appendix B – Immediate Improvement plan

Service: Ysbyty Gwynedd

Area: Maternity Services

Date of Inspection: 25 – 27 November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
N/A				

Appendix C – Improvement plan

Service: Ysbyty Gwynedd

Area: Maternity Services

Date of Inspection: 25 – 27 November 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 resource and availability of perinatal support is reviewed.		The Directorate is working in partnership with the Perinatal Mental Health Service to ensure that all relevant information and support is available to all women. The Perinatal Mental Health Service is located on the Glan Clwyd Hospital site. North Wales has a full complement of Perinatal Mental Health practitioners and	Perinatal Mental Health Specialist Midwife Perinatal Mental Health Specialist Team	Commenced and ongoing Complete

		therefore all six Counties have a named professional. The Perinatal Mental Health Service has a robust training programme for 2020 which commenced in January. The training includes 'Training the trainer' for *Infant and Health Visiting Perinatal Mental Health*. The Women's Professional Development Midwife attended the training in January 2020, with a plan to identify midwife champions in all clinical areas and cascade this specialist knowledge.	Perinatal Mental Health Specialist Team Professional Development Midwife	Complete Commenced To be completed by April 2020
The health board must ensure that discussions regarding birth choices take place and are documented accordingly.	3.5 Record keeping.	All pregnant women are given a copy of the Betsi Cadwaladr University Health Board Birth Choices Leaflet to facilitate discussion regarding options for birth. All staff have been reminded to document Birth Choice discussions within the Hand Held Notes. This will be monitored at the Clinical Supervisors for Midwives monthly notes audit.	Community midwives Operational lead manager	Complete Complete

		Birth Choice Clinics commenced within the maternity unit in Ysbyty Gwynedd in January 2020. Feedback from women on this service introduction will be collated and presented to the Women's Quality Safety and Experience (QSE) sub group on a quarterly basis. This will then feed up to the Board through the Corporate Quality safety Group (QSG).	Midwifery Led Unit lead midwife	Complete
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	1.1 Health promotion, Projection and Improvement	The contact details for the Community Health Council are displayed and available in all clinical areas. This compliance is monitored on the Matron daily walkabout on the unit.	Inpatient Matron	Complete
Delivery of safe and effective care				
The health board must ensure that hand sanitiser gels are available for use.	2.1	Fully operational hand sanitiser-dispensing pumps available at every bed space and throughout the unit. Compliance with this will be checked by the housekeeper and Health Care Support Worker on a daily basis.	Ward manager	Complete

The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	1.1 Health promotion, Projection and Improvement	All midwives receive an annual update on breast-feeding and are available to support women on an individual basis when required. There is also a dedicated page on the Health Board's website. The Infant Feeding Co-ordinator is available to support staff to provide care to women and babies presenting with cases that are more complex. A business case has been developed with options of how we can improve and further support breast-feeding support workers as part of a Quality Improvement Project. Awaiting a response from Finance. Pending approval from Finance the Directorate will be recruiting in March and staff will commence in May 2020.	Ward manager Infant Feeding co-ordinator North Wales Strategic Infant Feeding Group	Complete Complete Complete May 2020
The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	3.4 Information Governance	The Women's Written Control Document Group has an action plan that lists all policies and guidelines developed, which includes revision dates.	Written Control Document Group	Complete

		All policy/guideline authors are approached by the appropriate Forums within Women's Services when policy review is required.	Forum Chair	Complete
		Authors of all outstanding policies are regularly reminded to submit their updated versions to the relevant governance group for approval in a timely manner. A tracker has been developed to support the monitoring of this action.	Written Control Document Group	Ongoing
		A memo from the Director of Midwifery & Women's Services and the North Wales Clinical Lead was circulated in December 2019 to all staff, detailing the need for WCD authors to comply with the required timeframes for updates.	Director of Midwifery & Women's Services North Wales Clinical Lead	Complete
		Agreement was reached at the Women's Quality, Safety & Experience Sub-Group (QSE), that a list of policies, authors and due dates should be shared with the site triumvirate leadership teams, to enforce and support lines of accountability.	QSE Group members	Complete

		Written Control Document expiry dates have been extended to March 2020 to ensure staff are fully aware that the Written Controlled Documents on the intranet remain live for their support.	Written Control Document Group	March 2020
		The Health Board have developed a formal route for written control documents to ensure that any policies approaching their expiry date, are reviewed and updated in a timely and appropriate manner.	Written Control Document Group	Commenced and ongoing
		The Director of Midwifery and Women's Services and North Wales Clinical Lead are monitoring the progress made at monthly Senior Management Team meetings.	The Director of Midwifery and Women's Services	Complete
		Bi-weekly meetings have been arranged for the Chairs of the Women's Directorate Forums, the Governance lead and the Director of Midwifery to monitor progress and performance against the Written Controlled Document action plan.	North Wales Clinical Lead	Complete and on-going
				Complete and on-going

		A Written Controlled Documents progress report is reviewed at the Women's QSE Sub-Group on a quarterly basis.	Written Control Document Group	
The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping.	3.5 Record Keeping	Clinical Supervisors for Midwives discuss documentation standards, which includes the care and treatment provided to women, during their presentations on mandatory training days. These sessions are delivered every two years alternating with enhanced communication sessions as part of an agreed Training Needs Analysis for the Directorate. These sessions are open to both midwifery and medical staff. The Clinical Supervisors for Midwives also provide monthly notes audit sessions for staff, where they can review sets of notes and learn directly from any good/poor practice identified during the session. The audit results are also fed back at Group Supervision sessions, which each midwife is mandated to attend annually. The results are also	Clinical Supervisors for Midwives Clinical Supervisors for Midwives	Ongoing Ongoing

		presented to Women's QSE sub group annually. Each midwife is required to audit two sets of their own records from the previous year to discuss at a group Supervision session on an annual basis. The Clinical Supervisors for Midwives also support documentation sessions for medical staff on their induction programme and highlight the need to include the care and treatment provided to women within their medical documentation. Stamps have been re-ordered for all staff to use alongside their signature when documenting an entry in a woman's notes.	Clinical Supervisors for Midwives Clinical Supervisors for Midwives Women's Operational Team	Complete Complete Complete
Quality of management and leadership				
The health board must ensure that CTG training is reviewed to cover the introduction of new processes e.g. CTG assessment stickers.		All new documentation is made available for staff consultation prior to implementation. Clinical Supervisors for Midwives also post information with regards to the	Senior Management Team Site Management Teams	Commenced and on-going

		introduction of new documentation on the midwifery hub. All midwives and obstetricians are required to complete six hours of face-to-face CTG training per annum. Training sessions include interpretation of a CTG using the antenatal and intrapartum CTG stickers implemented across the Women's Directorate. Midwifery CTG champions have been identified in each maternity unit. Midwifery CTG champions are in the process of completing a training programme that includes attending an RCOG study day and working with other CTG national champions. Following completion of the training, the champions will be responsible for delivering the training to midwives and obstetricians within the Directorate.	Clinical Supervisors for Midwives CTG champion midwives. Professional Development Midwife. Consultant Obstetricians CTG champion midwives. Professional Development Midwife. Consultant Obstetricians	Complete Commenced and on-going Commenced and with completion date of April 2020

The health board must ensure that medical work plans are reviewed to ensure adequate medical cover is in place at all times.	7.1 Workforce	An external independent review of medical rotas has been completed, as part of the health board's medical workforce review strategy. An independent review of job plans is scheduled for 7 February 2020.	Executive Medical Director Executive Medical Director	Completed Commenced and completion date March 2020.

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): **Fiona G Giraud**

Job role: **Director of Midwifery and Women's Services**

Date: **17-1-2020**