Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Announced)

Community Hospital Free Standing Birth Unit – Maternity Services, Aneurin Bevan University Health Board

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

Our purpose

To check that people in Wales are receiving good care.

Our values

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

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of the Community Hospital Birth Unit within Aneurin Bevan University Health Board on the 4 February 2020. This inspection is part of HIW's national review of maternity services across Wales[1].

The following hospital free standing birth unit was visited during this inspection:

- Ysbyty Aneurin Bevan with a capacity of one birthing room including a birthing pool and one clinical room.

Our team, for the inspection comprised of two HIW inspectors and two midwife clinical peer reviewers. 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 were positive about the care and treatment provided during appointments attended in the unit
- We observed professional, kind and dignified interactions between staff and patients
- There was a good range of health promotion information displayed
- Care was well documented throughout the notes.

This is what we recommend the service could improve:

- Defective doors and equipment are reviewed
- Review of audit completion and recording
- Record keeping.

5. What we found

Background of the service

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

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

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

The health board averages around 6,000 births per year, however there has not been any births within Ysbyty Aneurin Bevan since 2018.

Women who birth within the health board have the choice of four birth settings. These include homebirths, a free-standing midwife unit, midwife led care at an alongside midwife unit and an obstetric unit. A freestanding midwifery led birthing unit is based at Ysbyty Aneurin Bevan comprises of one birthing room, one birthing pool and a clinical room.

Quality of patient experience

We had feedback from patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the unit of our approach to inspection.

Patients were positive about their overall experience of the service and felt they had always been treated with dignity and respect.

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

Health promotion was clearly displayed within the birthing unit.

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 7 questionnaires were completed. Unfortunately, we were unable to speak with any patients directly during the inspection. However, women were attending antenatal clinics during our inspection.

Comments from patients who completed questionnaires included:

> *"Lovely, engaging staff who put me at ease at each of my antenatal appointments"*

> *"the staff very friendly and caring"*

Staying healthy

Across the unit, we saw adequate information displayed for patients on notice boards, and leaflets were readily available to inform patients of how they can stay safe and healthy.

Information in relation to breastfeeding and skin to skin advice was displayed within the unit, to inform patients about the benefits of both breastfeeding and skin to skin contact with their baby, to help them make an informed decision about their care. Hand hygiene posters and hand washing guides were also displayed.

We also saw information in relation to smoking cessation throughout the unit. We were also told that the health board had recently appointed a smoking cessation lead to provide support and information to patients. We also found from a sample

of patient care records reviewed, that public health messages were clearly documented, for example smoking cessation advice.

This information was seen in both English and Welsh throughout the unit.

Dignified care

During the course of our inspection, we saw examples of staff being kind and compassionate to patients. We saw staff treating patients with respect, courtesy and politeness at all times. The majority of comments within the patient questionnaires were also very positive. We reviewed care documentation and did not find any areas of concern regarding dignified care.

There were en-suite facilities within the birthing room on the unit which helped promote patients' comfort and dignity during their stay. However, the door to the en-suite did not close properly and therefore not allowing privacy for the patient.

All patients who completed questionnaires told us that the ward was clean and tidy. Patient comments included:

"Very clean and light."

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 and support to protect their privacy and dignity.

Most patients who completed questionnaires told us they saw the same midwife in the birthing unit as they did at their antenatal appointments. The majority of patients were six to twelve weeks pregnant when they had their booking appointment, and all patients told us that they had been offered a choice about where to have their baby.

All of the patients who completed questionnaires agreed the midwife asked how they were feeling and coping emotionally in the antenatal period. All patients agreed that staff were always polite to them and to their friends and family, and agreed staff listened to them, their friends and family.

Improvement needed

The health board must ensure that all doors within the unit are in a suitable working order to maintain dignity and privacy.

Patient information

We found that directions to the unit were clearly displayed throughout the hospital. This made it easily accessible for people to locate the appropriate place to attend for care.

When access was required out of core hours, signs were clearly displayed to direct people appropriately to the birthing unit. The unit can only be accessed by a staff swipe card or buzzer entry to maintain security.

Notice boards throughout the unit highlighted a wide range of health promotion, such as breastfeeding, Putting Things Right[2], Pregnancy Yoga at Nevill Hall Hospital, Birth Place Decisions and Baby Movements.

The responsive feeding team allows parent's easier access to help and support related to both breast and artificial feeding. This is a good initiative because it could improve breastfeeding success and ease of access to a professional who is able to spend time to establish breastfeeding. It is also a good example of cross service collaboration, since it is not just midwives who deliver this service.

The Welcome to the World Parent Group is another good example of cross service collaboration delivering key messages and providing support to women and families.

We did not see any information available to patients who were attending the unit or the antenatal clinic about staff that were on shift that day, for example a staff Who's Who board.

Improvement needed

The health board must ensure that options for informing patients of staff on duty are reviewed.

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

Communicating effectively

Overall, patients seemed to be positive about their interactions with staff during their time in the unit. All patients who completed questionnaires told us they were offered the option to communicate with staff in the language of their choice.

The use of language line was available for those patients whose first language was not English, meaning they were able to access care appropriate to their needs. However, from a sample of patient care records reviewed we found no documented evidence to suggest that communication needs, including any need for interpreters or for the information to be made available in other languages was assessed during antenatal appointments.

Staff we spoke with were aware of the translation services within the health board and how they were able to access these for patients who had difficulty understanding English.

We saw that staff tried to maintain patient privacy throughout the unit when communicating information. It was usual practice for staff to close doors of consultation rooms when providing care to protect patients' privacy and dignity.

Timely care

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

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

Individual care

Planning care to promote independence

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

We found that family or carers were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. Open visiting was available, allowing the partner, or a designated other, to visit freely.

We were told that patient's personal beliefs and religious choice would be captured during antenatal appointments, with a view to ensuring they were upheld throughout their pregnancy, during labour and postnatal care.

Patient's birth plans were also seen to promote independence by demonstrating birth place choices being met when clinically possible.

People's rights

As this was a freestanding midwifery led unit[3], visiting times were flexible. The birthing room was private, meaning that birthing partners or other family members could be present before, during and after giving birth, according to the woman's wishes.

All patients who completed the questionnaires agreed staff called them by their preferred name.

The birthing room within the unit was equipped with a birthing pool, a birthing ball and birthing mat and a bed to help meet the patients' birth choices.

We were told that to promote the birth options available to patients and to provide information to help them make an informed decision, discussions took place at initial booking appointments and throughout the pregnancy. This was also evident from the completed questionnaires with all respondents agreeing that staff had explained their birth options and any risks related to their pregnancy and the support they had been offered. However, from a sample of patient care records reviewed, we found no documented evidence to suggest that discussions were held with patients regarding their birth choices.

Listening and learning from feedback

We saw information leaflets and posters throughout the unit relating to the complaints procedure, should women or their families have concerns they wish to raise. Information was also available on raising concerns and advocacy support on the health board's website. We were told that staff were fully aware of the NHS process for managing concerns - Putting Things Right, and how to deal

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

with complaints. Staff confirmed that they were aware of how to deal with complaints but that they did not routinely provide patients with details of the Community Health Council (CHC)[4], who could provide advocacy and support to raise a concern about their care.

Improvement needed

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

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

Delivery of safe and effective care

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

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

However, we identified areas for improvement regarding infection prevention and environmental aspects, such as faulty equipment.

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

The service adhered to appropriate arrangements for safeguarding procedures, including the provision of training.

Safe care

Managing risk and promoting health and safety

We found that the unit was visibly well maintained, clean, appropriately lit and well ventilated. The unit was well organised with a maintained stock of medical consumables.

We looked at the 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 identity pass or by a member of staff approving entrance.

We looked at the arrangements within the unit for accessing emergency help and assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells to summon assistance quickly.

We noted there was appropriate emergency equipment within the birthing unit to remove patients quickly from the pool. We were assured that all staff had received appropriate training in the use of this equipment in the case of emergency and we saw the policy which was in place.

Falls prevention

We saw there was a risk assessment in place for patients admitted into the unit and those using birthing pools. We were informed that any patient falls would be reported via the health board's electronic incident reporting 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 birthing unit were clean and tidy, and we saw that personal protective equipment was available in all areas and was being used by all healthcare professionals. Patients who completed a questionnaire thought the unit was well organised, clean and tidy.

During the inspection, we observed all staff adhering to the standards of being Bare Below the Elbow[5] and saw good hand hygiene techniques. Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. Hand hygiene gels were also available throughout the unit.

We were also assured that infection prevention and control training compliance was to a high standard, and any concerns that were raised regarding infection prevention and control would be escalated to senior members of staff. We saw results from an infection control audit which has recently had been carried out by the health board. This audit showed that compliance with infection control was high and any work required was appropriately dealt with in a timely manner. However, we found that the audit data was not easily accessible in the birthing unit, and was stored elsewhere within the maternity services. The inspection team advised it would be good practice to store such data in house to be able to show evidence when required.

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

[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.

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

Improvement needed

The heath board must ensure that all audit data for the birthing unit is easily accessible for review.

Nutrition and hydration

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

Within the community hospital, there were facilities available to purchase drinks if required. We were also told by staff that water jugs and tea and coffee facilities would be made available in the birthing room, however, due to reduced activity within the unit, we were unable to see evidence of this.

Medicines management

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

We observed the storage, checks and administration of drugs to be safe and secure.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be vulnerable or at risk. All staff we spoke with confirmed that they had received mandatory safeguarding training within the past 12 months.

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

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

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

Medical devices, equipment and diagnostic systems

We found the checks on the neo-natal resuscitaire[6] to be consistently recorded demonstrating that they had been carried out on a daily basis.

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

Effective care

Safe and clinically effective care

The majority of staff who completed a questionnaire shared that they were usually happy with the quality of care they were able to give to their patients within the birthing unit. We were told by staff that patients in the birthing unit would always be kept comfortable and well cared for. We also saw good evidence of assessment and treatment plans throughout the patient records reviewed. Due to the reduced activity of the birthing unit, we were unable to see clinical need prioritisation, however for the two medical records we reviewed, it was evident that clinical need prioritisation was forefront in care planning.

We were told that there is a breastfeeding coordinator appointed within the health board, staff also said that they would feel happy to give breastfeeding advice

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

when required. Staff and senior managers told us that the substantial workload covered by the breastfeeding coordinator 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 free standing birthing unit.

Quality improvement, research and innovation

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

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

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

Information governance and communications technology

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

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and procedures. The unit also had access to the Ysbyty Ystrad Fawr birthing unit's standard operating procedure which was agreed by the inspection team to be good practice.

We found that a monthly maternity dashboard was produced which included information in relation to each hospital and across the health board. This provided information with regards to the clinical activity, however as previously discussed, reduced activity within the birthing unit meant that this provided limited data.

Record keeping

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

We considered a sample of midwifery patient records within the unit. Records showed that pain was being assessed and managed appropriately. Appropriate risk assessments, including those for deep vein thrombosis, had been completed.

However, in one patient's records we saw inconsistency in the routine enquiry form being completed.

We did however, see good accountability and signage within the three maternity records we reviewed.

Improvement needed

The health board must ensure that concise record keeping is maintained.

Quality of management and leadership

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

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

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

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

Governance, leadership and accountability

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

We could see that there was a good level of oversight of clinical activities and patient outcomes. A monthly maternity dashboard was produced, which included information in relation to the whole health board, but also broken down to each hospital. This provided information on the clinical activity on the unit i.e. number and category of births (vaginal, caesarean section, assisted), induction of labour, and also clinical indicators and incidents, such as complaints, investigations, eclampsia[7], intensive care admissions, blood transfusions, neonatal admissions and neonatal morbidity. The dashboard was rated red, amber and green

[7] Eclampsia is the onset of seizures during pregnancy

depending upon the level of risk, meaning that prioritisation in risk management could be managed appropriately.

In addition, the senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBBRACE)[8] and Each Baby Counts[9] 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 saw evidence of audit completion, such as internal infection prevention audits for hand hygiene. We also saw recent evidence of health and safety audit compliance, however at the time of the inspection, we did not see evidence of regular fire drill audits being carried out within the community hospital. We were also not assured that there was a robust logging system in place within the unit for completed audits.

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in post, who held responsibility for monitoring and reviewing clinical management of multidisciplinary investigations. All staff we spoke with, told us that the organisation encourages them to report errors, near misses or incidents and that these were not dealt with in a punitive manner. However, we were told that not all staff were given the opportunity of non-clinical time, allowing them to review incidents appropriately, which would be seen as good practice.

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead governance midwife also presented themes and trends to this meeting, with the view of highlighting any areas of practice, which

[8] 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-unitd maternal, newborn and infant health services.

[9] 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.

were in need of addressing across the heath board. Following this meeting, a monthly feedback newsletter was produced and circulated to all staff, summarising the month's issues. We also saw that this newsletter was used to provide positive feedback to staff, and to highlight where good practice had been evident. We saw that minutes were produced and information/learning shared across maternity services across the health board to support changes to practice and learning. This information also included other maternity sites within the health board, with a view to sharing best practice and any learning to improve practice and processes.

Improvement needed

The health board must ensure that regular fire drill audits are carried out, with the inclusion of the birthing unit.

Staff and resources

Workforce

Due to the limited activity within the areas we visited, we were unable to speak to more than two members of staff, we also did not received any completed staff questionnaires during or after the inspection.

We were told by the staff that midwifery rotas were managed well within the unit we visited.

We saw there were departmental escalation processes in place and staff we spoke with were aware of where to locate the policy and how to escalate issues, such as staffing shortages.

We saw evidence of robust induction programmes for midwifery staff, and staff felt these were of benefit when commencing their role.

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 Practical Obstetric and Multi-Professional Training PROMPT training, which is a multidisciplinary training event used to encourage effective

multidisciplinary working in emergency situations. All staff we spoke with, told us they attend the training when they can, and find it very useful. We were shown compliance figures for PROMPT training and were assured that training was appropriately taking place in the correct timescales.

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

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

Three clinical supervisors of midwives were in place across the health board. Their roles were to provide support and professional supervision to midwifery staff. There is a national target to ensure that supervisors meet with midwives for four hours[10] each year. The health board started to monitor compliance with this target during the previous financial year and were continuing to monitor it on an ongoing basis.

The clinical supervisor of midwives was also responsible for carrying out appraisals. We were told that within Ysbyty Aneurin Bevan, all appraisals were up-to-date. Staff we spoke with told us they have regular appraisals and they see them as positive meetings to help identify further training opportunities, and to increase continuous professional development.

We found that there was a good level of support in place from the specialist lead midwives. Whilst they were not based at Ysbyty Aneurin Bevan, we were told that they made efforts to be visible and approachable to staff within the unit. Information provided to us during the course of the inspection demonstrated that they were knowledgeable about their specialist roles, and they provided support

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

and guidance through study days, supervision sessions and meetings with staff as and when required.

6. 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.

7. 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 Aneurin Bevan, Free Standing Midwifery Led Unit Birthing Unit - FMU

Area: Maternity Services

Date of Inspection: 4 February 2020

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 Aneurin Bevan, Free Standing Midwifery Led Unit Birthing Unit - FMU

Area: Maternity Services

Date of Inspection: 4 February 2020

N/A

Health Board Representative:

Name (print): ……

Role: ……

Date: ……

Appendix C – Improvement plan

Service: Ysbyty Aneurin Bevan, Free Standing Midwifery Led Unit Birthing Unit - FMU

Area: Maternity Services

Date of Inspection: 4 February 2020

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 all doors within the unit are in working order to maintain dignity and privacy.	4.2 Patient Information	The door of the en-suite facility within the birthing room was not closing properly, which was not allowing privacy for the patient. This has been reported to works and estates for repair. Works and Estates Call Ref number 5811575 Job repaired	Deb Jackson Head of Midwifery	Complete Evidence Supplied

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that options for informing patients of staff on duty are reviewed.	4.2 Patient Information	A notice board has been created with the names of staff working in the birth unit. It also identifies which midwife is currently on duty visible to all women and their families.	Deb Jackson Head of Midwifery	Complete Evidence Supplied
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	4.2 Patient Information	Leaflets have been requested from the Community Health Council for display in public areas to ensure patients are aware that the Community Health Council provide advocacy and support to raise a concern about their care. This request was made on 17.06.2020.	Deb Jackson Head of Midwifery	Awaiting arrival of the leaflets
Delivery of safe and effective care				
The heath board must ensure that all audit data for the birthing unit is easily accessible for review.	3.1 Safe and Clinically Effective Care	Audit data for the birthing unit is stored electronically – moving forward Midwives will make this data more readily accessible in a hard copy format.	Deb Jackson Head of Midwifery	Complete Evidence Supplied

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that concise record keeping is maintained.	Governance, leadership and accountability 3.1 Safe and Clinically Effective Care	Appropriate record keeping is audited and reviewed by the Supervisors of Midwives and shared with the Head of Midwifery and the wider multidisciplinary team at Clinical Governance Meetings. The Supervisors look for good accountability and signage and ensure all risk assessments are appropriately managed. A Notes audit has been undertaken by the Supervisors of Midwives in November 2019. An RE1 (Routine Enquiry audit has been completed by the safeguarding midwife which describes the results in accordance with Standard 2 of the All Wales Pathway Antenatal Routine Enquiry into Domestic Abuse Minimum Standards Policy (2006).	Supervisors of Midwives Deb Jackson Head of Midwifery Safeguarding Lead Midwife	Complete Evidence Supplied

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must ensure that regular fire drill audits are carried out with the inclusion of the birthing unit.	Governance, leadership and accountability 2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care	Audit drills are performed at Ysbyty Ystrad Fawr with inclusion of the Birthing Pod. Audit evidence are currently stored electronically and will be made visible for review in a hard copy format.	Deb Jackson Head of Midwifery	Complete Evidence Supplied

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): Deb Jackson

Job role: Head of Midwifery

Date: 26th June 2020