

Inspection Summary Report

Maternity Unit, University Hospital of Wales,
Cardiff and Vale University Health Board

Inspection date: 8 - 10 November 2022

Follow up Inspection date: 27 - 29 March 2023

Publication date: 21 June 2023



This summary document provides an overview of the outcome of the inspection



Overall Summary

We completed a full inspection of the Maternity Unit in November 2022. Due to the volume and seriousness of significant issues found, we felt it necessary to undertake a prompt follow up inspection to ensure steps had been taken to improve the service and ensure patient safety. We completed a follow up inspection in March 2023. Our main report and this summary cover both inspections.

Our follow up inspection noted some improvements had been achieved, but also identified further issues of concern. Overall progress in addressing the areas of concern was mixed, with some actions not fully embedded across the service and a need to increase the pace of improvement. Issues remain around leadership and governance, patient experience, Infection Prevention and Control and medicines management.

At the time of first inspection, we found that the Maternity unit had experienced a sustained period of low staffing levels. We found low morale amongst staff that we spoke to, and in our staff survey. We acknowledged that low staffing levels meant that staff were working hard to deliver care for their patients in challenging circumstances. Many staff members went above and beyond to ensure that their patients were well cared for.



The majority of patients we spoke with were happy with the way that staff interacted with them, and the care provided. However, many could see the pressures the staff were working under and some avoided asking for help. Patients also told us that issues around privacy and dignity, choice, and timeliness of pain relief negatively impacted their experience.

Our first inspection noted issues of some Black, Asian and Minority Ethnic women feeling like they were being treated differently. The health board has since implemented a number of initiatives and strategies to improve the experience of Black, Asian and Minority Ethnic patients. These improvements must be sustained and the health board needs to ensure it engages with relevant patients to check the effectiveness of these initiatives.

We highlighted significant concerns regarding many aspects of the delivery of safe and effective care in both inspections. We were not assured that the processes and systems in place were sufficient to ensure that patients consistently received an acceptable standard of timely, safe and effective care. This included routine items of maintaining cleanliness, daily checking of essential maternity equipment and safely storing medicines. Concerns were also highlighted around the issues of staffing, training and escalation. However, we found that women with complex medical needs were generally well supported and that multidisciplinary team working was positive. We also noted some areas of good practice for example around automating processes to release time to care.



We were not assured following our initial inspection that there was a supportive culture in place which promoted accountability and safe patient care and that the management and leadership was sufficiently focused and robust. We saw that the service held regular governance meetings to improve services and strengthen governance arrangements. Senior managers told us they aimed to be a visible presence on the unit. Whilst we noted that senior managers had implemented initiatives to address this area of concern and improve visibility following the first inspection, responses to our staff survey were very mixed with staff struggling to cope with their workloads, not considering senior staff to be visible, and not promoting a good culture of learning from adverse events.

We saw some areas of good practice, for example the Elan team working with patients who require additional support, and we were told of a significant investment in the Maternity unit of over £2 million which would include a significant investment in staffing.

Note the inspection findings relate to the point in time that the inspection was undertaken.

What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our [website](#).

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Maternity Services at University Hospital of Wales, Cardiff and Vale Health Board on 8-10 November 2022. During the inspection, HIW identified several patient safety concerns and we issued an immediate improvement notice on 16 November 2022. HIW undertook a further follow-up inspection on 27 - 29 March 2023.

Our team for the inspection comprised of three HIW Healthcare Inspectors, two clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector. The follow-up inspection comprised of three HIW Healthcare Inspectors, three clinical peer reviewers and one patient experience reviewer.

This summary version of the report is designed for members of the public.

A full report, which is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our [website](#).



Quality of Patient Experience



Overall Summary

We found that staff worked hard to provide patients with a positive experience despite the pressures on the department. Staff were observed providing kind and respectful care, and patients we spoke to were generally positive of the care they received from staff. However, some patients raised concerns about staff availability and sufficient support. This negatively impacted timely care, and patient dignity and privacy.

During the inspection in November 2022 a patient questionnaire was distributed, we received 370 responses from patients. Three quarters who answered rated the service as 'very good' or 'good,' and a quarter as 'poor' or 'very poor.' Notably, we did receive some comments from patients related to discrimination around ethnicity and race on the wards as well as via the patient questionnaire.

Where the service could improve

HIW highlighted the following serious issue which required immediate action by the health board during the inspection November 2022.

This related to the experience of a woman being treated differently due to their ethnicity and skin colour. Prior to and during the follow up inspection in March 2023, HIW received acceptable assurance and evidence of ongoing action taken.

In addition to the immediate assurance highlighted above, this is what we recommend the service can improve:

- Improve signage to different areas of the unit
- Care for patients within the right clinical areas for their stage in pregnancy
- Address the environment in the induction of labour ward to effectively promote patient privacy and dignity
- Improve the choice for women with low risk pregnancies to receive their care in a non-medicalised environment if they wish
- Increase support for patients from Black and minority ethnic backgrounds.

What we found this service did well

- The majority of patients and families told us they felt well cared for
- Women with complex medical issues were well supported
- Patient records we reviewed were comprehensive, and fully documented patient expressed wishes and individual needs

- Welsh language maternity care was available
- The ELAN service and women seeking sanctuary services
- The bereavement and perinatal services were seen to be very supportive
- Baby Friendly 2022 accreditation had been awarded.

Patients told us:

“My birth experience was fantastic and the staff at UHW were brilliant!”

“The setting was perfect; I gave birth in the midwife led unit and the facilities were above and beyond what I expected”

“It felt that some of the midwives were treating me in a different way because I’m an immigrant”

Delivery of Safe and Effective Care



Overall Summary

Patient records we reviewed confirmed daily care planning which promoted patient safety and evidenced the care provided. However, in November 2022, we raised significant concerns around infection prevention and control, cluttered areas, security, and staffing.

Whilst we observed some improvements between November 2022 and March 2023 we found evidence that general infection prevention and control measures were not sufficiently robust in all areas. We found that medicine management storage processes were insufficient, routine checking of all essential equipment was not always recorded and there was insufficient management and security processes related to confidential patient information.

We saw that three of the four lifts servicing the unit were out of order in March 2023. There were insufficient plans in place to protect the dignity and safety of women and babies in the event of all lifts malfunctioning.

We observed good multidisciplinary team working across services such as neonatal, pharmacy, theatres and anaesthetics.

We noted the efficiency improvements in relation to the online booking appointment as well as the automation of some processes that had increased the time available for staff to care for patients.

Where the service could improve

HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff.

The following issues were raised in an immediate assurance letter issued following the inspection in November 2022 and subsequently closed due to sufficient assurances being received in March 2023.

- We were made aware of incidents where obstetric emergencies had not been responded to in a timely and effective manner
- Due to staffing, training, and senior support deficits, we were not assured that staff would be able to respond safely and quickly to emerging patient

risk. We were advised of, and observed, specific incidents and issues with care pathways

- The clinical areas and corridors were cluttered with equipment, cleaning equipment, fluids and trolleys
- Insufficient security measures, drills, training and checks were in place to ensure that babies were kept safe and secure
- Hand hygiene audits were not being undertaken on a regular basis with the last audit completed in August 2022
- Other infection prevention and control audit activities were not routinely taking place and the health board could not provide evidence to show that actions had been taken, tracked and monitored as a result of audits that were completed.

The following issues were raised in an immediate assurance letter issued after the follow up inspection in March 2023 (these included some assurances from November 2022 that were not resolved):

- Medicines including controlled drugs were not securely stored in some areas of the unit
- Medicines storage temperatures not routinely monitored in some areas of the unit
- Harmful cleaning fluids were not stored appropriately and safely
- Waste management of sharps was not effectively and safely managed
- Theatre areas (in November 2022) and rooms for care and treatment (in March 2023) were observed to be visibly soiled with what appeared to be blood and bodily fluids
- Routine cleaning schedules were incomplete
- Daily checks of essential maternity equipment including resuscitaires and defibrillators not always recorded
- No timely plans in place to protect the safety and dignity of women and babies in the event of all lifts malfunctioning in the unit
- Insufficient management and security of confidential patient information.

In addition to the Immediate Assurance issues above, this is what the service must improve:

- Review 24 hour maternity theatre staffing in line with other specialities
- Review and risk assess birth partner use of scrubs / effective PPE when attending theatre for caesarean section
- Ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment.

What we found this service did well

- Good multidisciplinary team working was seen across services such as neonatal, pharmacy, theatres and anaesthetics
- The efficiency improvements in relation to the online booking appointment and other efficiency savings around automation through the digital midwife had increased the time available for care
- Good health promotion information was available across the unit which included a wide range of relevant services and information
- Patient records documented clinical need as the primary focus of care planning.

Patients told us:

*“Inadequate clean sheets provided - I was changing the beds myself. Only saw a cleaner once during inpatient stay - improved cleaning would have improved the inpatient stay”
(March 2023)*

“Felt like there was a general lack of resources...” (November 2022)

“The whole place from antenatal to ward could do with a good scrub.”(November 2022)

Quality of Management and Leadership



Overall Summary

During the follow up inspection in March 2023 we noted some changes within the senior team with a new Divisional Director, plans to recruit Director of Midwifery and the Clinical Director stepping down. We saw that the service held regular governance meetings to improve services and strengthen governance arrangements. Senior managers told us they aimed to be a visible presence on the unit and were making efforts to build up confidence and trust between the unit staff and senior management. Midwifery staff gave positive feedback about their immediate line managers and generally said they could be relied on to help with difficult tasks.

The majority of midwifery staff that we spoke to told us they were struggling to cope with their workloads and poor working environments. Responses to questions on our staff surveys (in November 2022 and March 2023) on the visibility of senior staff, workload and quality of care were very mixed. We saw a small improvement in these responses between inspections.

We had concerns over staffing shortages and in March 2023 it was confirmed that more than £2 million investment will be used to increase staffing levels in the department, all staff that we spoke were optimistic about improvements in staffing levels.

We were not assured that there was a supportive culture in place which promoted accountability and safe patient care and that the management and leadership was sufficiently focused and robust. However, during the follow up inspection we noted some improvements related to the investigations process with the appointment of key staff members and changes to the investigation process.

Where the service could improve

The following issues were raised in an immediate assurance letter issued following the inspection in November 2022 and subsequently closed due to assurances being received in March 2023.

- The unit frequently did not have sufficient staff, or sufficient skill mix to maintain basic safety standards

- Serious incident investigations had extended timescales for investigation and the initial reviews did not always pick up important issues for immediate learning
- Poor mandatory training compliance including key clinical skills.

In addition to the Immediate Assurance issues above, this is what the service must improve:

- Reintroduce team meetings for Maternity Support Workers, band 5 and band 6 team midwives
- Review rota effectiveness for non-clinical midwives to support clinical area
- Recruitment and retention processes
- Review and improve induction process for band 5 staff
- Ensure adequate breaks or time outs for staff
- Review the way in which incidents and concerns are investigated
- Monitor training compliance.

What we found this service did well

- Band 7 team members were seen to be supportive and passionate about their role in supporting staff and encouraging continuous professional development
- Research in obstetrics, piloted and led by the health board, now being rolled out across the UK
- Individuals and initiatives within the departments being receiving nominations for awards for best practice
- Efficiency savings for processes to enable time to care
- Clinical Supervisors for Midwives gave good support when workloads enabled this to happen.

Staff told us:

Staff provided us with the following comments:

“There has not been allocated time in the rota to complete our e learning. Due to high service demand then there is no time for on-the-job training”

“We struggle when there are not enough staff to care for the amount of women with increasing high-risk needs”

“I enjoy working in this unit. There is a strong culture of multidisciplinary teamwork and mutual respect amongst different professionals.”

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition, we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.

