Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Cwm Taf University Health Board/ The Royal Glamorgan Hospital / Maternity Services

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

Our purpose

To check that people in Wales are receiving good care.

Our values

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

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of maternity services within Cwm Taf University Health Board on the 15, 16 and 17 October 2018. The inspection was in response to a number of concerns highlighted regarding the provision of safe care, staffing issues, incident reporting and the stability of the service.

The following hospital sites and wards were visited during this inspection:

The Royal Glamorgan Hospital

- Ward 10
- Ward 11
- Labour ward.

Our team, for the inspection comprised of two HIW Inspectors (an inspection lead and clinical director), a clinical peer reviewer and lay reviewer.

The inspection commenced the evening of the 15 October, and continued over the following two days.

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

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

2. Summary of our inspection

Overall, we had concerns about the sustainability, resilience and the ability of the service to provide care and treatment in a safe and effective way.

Despite the best efforts and dedication of staff working very hard on the wards, we found that the service had significant staffing issues. This impacted on the delivery of safe and effective care in a number of ways, including

- Staffing issues adversely impacting upon the health, safety, morale and well-being of staff
- Staff responsible for reviewing incidents and concerns told us they were often unable to do this in a timely manner
- Staff were often unable to attend mandatory training to ensure they maintained the skills and knowledge to carry out their roles
- Essential duties, such as on ward audits, were not being carried out.

Whilst staff told us that they felt supported by their direct line managers, it was concerning to find that many described the working environment as difficult. Many did not feel action would be taken by the organisation to address or learn from incidents and concerns.

We found that there was a disconnect between a number of professional groups across the service, which impacted on effective multidisciplinary working.

As a result of our findings, we were not assured that there were sufficient governance processes and oversight in place to ensure that activities such as audit were being undertaken in order to

improve the service or take action where there were issues.

We recognised that the health board had attempted to make changes to improve staffing, culture, training and governance of the service. However, any changes were in their infancy and yet to be fully embedded.

For the health and well-being of staff, and to ensure the service is able to provide safe and effective care to patients, the health board is required, as a priority to take action to address these issues.

This is what we found the service did well:

- Patients told us that staff were kind and sensitive when carrying out care and treatment
- We observed care and treatment being delivered in a dignified way protecting patient privacy
- Staff were working hard to deliver patient centred care in very difficult and challenging circumstances.

Our findings in relation to some areas of concern resulted in HIW issuing an immediate assurance letter. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. The health board had seven days to provide HIW with full and satisfactory information about any action taken or planned, to address the concerns described. A brief summary of the issues included:

- Inability of the service to consistently staff all shifts with sufficient qualified and non-qualified staff
- Staff working long hours and extra shifts to cover staff shortages
- Skill mix of staff on shifts being potentially compromised due to staff being brought in from non-acute maternity services, with often different skills and experience, when covering shortages on shifts
- Inability of staff to complete mandatory training, review incidents, and complete ward audits due to staffing issues and clinical priorities
- Concerns relating to the sustainability of the service and the health and well-being of staff

- Checks on drugs and equipment used in a patient emergency not being checked regularly.

In addition to the issues set out in our immediate assurance letter, we also made recommendations for areas of improvement as outlined below:

- Availability of information for patients about the complaint process and advocacy services
- Security arrangements for access to the wards
- Ensuring adequate stock levels of personal protective equipment
- Some arrangements for the safe storage and checking of drugs
- Staff access to sufficient numbers of equipment such as sonicaids[1], cardiotocography[2] (CTG) monitors and blood pressure monitoring machines
- Communication with staff, in particular reference to service delivery changes
- Feedback to staff regarding concerns and complaints
- Ability of staff to review incident reports in a timely manner
- Audits on the wards and the governance arrangements for this activity
- Concerns around culture in relation to effective team working and staff health and well-being
- Training and supervision for staff.

Full details of the improvements identified during our inspection can be found in Appendix C of this report.

[1] A hand-held device for fetal monitoring

[2] A machine used to record the fetal heartbeat

3. What we found

Background of the service

Cwm Taf Health Board was established in October 2009 and achieved University status in July 2013. The health board provides primary, community, hospital and mental health services to people living in Merthyr Tydfil, Rhondda Cynon Taf and surrounding areas. The health board is also responsible for the provision of child and adolescent mental health services for south Wales and is the host body for Welsh Health Specialised Services and the Emergency Ambulance Services Committee.

The Royal Glamorgan Hospital provides acute emergency and elective medical and surgical services together with a range of diagnostic facilities.

The maternity service at The Royal Glamorgan Hospital consists of a delivery suite made up of five labour rooms. There is also an Alongside Midwifery Unit (AMU) providing midwife led care with two birthing rooms one having a birth pool.

Ward 10 has 22 beds (in a combination of bays and side rooms), providing both postnatal and antenatal care.

Ward 11 has five beds dedicated to providing high care to mothers who need extra support following birth and medical interventions such as caesarean sections. There is also a bay with six beds dedicated to providing triage services to patients, including providing care to patients who have had their labour induced.

Ward 11 also has a day assessment unit, which consists of five beds, where patients are able to access the service for day appointments, such as foetal monitoring and iron infusions. This area of ward 11 was not considered in detail during the inspection.

Maternity services at The Royal Glamorgan Hospital also comprise of an antenatal clinic, providing regular antenatal checks and scanning services. This area was not included during the inspection.

The health board recently confirmed that maternity services provided at The Royal Glamorgan Hospital will change with effect from March 2019[3]. The hospital will no longer provide consultant-led maternity services at The Royal Glamorgan Hospital, meaning that women in need of this service would be cared for at Prince Charles Hospital, Merthyr Tydfil.

[3] http://cwmtaf.wales/update-on-changes-to-maternity-and-childrens-inpatient-services-at-royal-glamorgan-hospital/

Quality of patient experience

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

We found a team committed to providing care and treatment to patients with dignity and respect. We observed staff being compassionate and protecting the privacy and dignity of patients and their families.

The ward environments were well maintained and generally uncluttered.

During the inspection we obtained patient views about the care and treatment received, by speaking directly with them and through completed HIW questionnaires. Patient comments included the following:

> *"The staff have been very supportive and caring"*
>
> *"I have chosen to transfer my care from (another hospital). My experience has been great and I am pleased to be here again"*

Discussions with patients and information collated in the questionnaires indicated that patients were positive about the care and treatment provided to them by staff.

Staying healthy

We found that there was information displayed on the wards providing information to patients about how to stay healthy, including smoking in pregnancy and healthy eating.

Dignified care

Patients were asked in the questionnaires whether they agreed or disagreed with a number of statements about the hospital staff. All patients agreed that

staff were always polite and listened, both to them and to their friends and family. All patients told us that staff called them by their preferred name.

We observed patient care being delivered sensitively, and where appropriate doors and curtains were closed to protect patient privacy and dignity.

The labour ward had individual rooms with shared bathroom facilities between two rooms. Ward 10 consisted of a mixture of single rooms and small bays with both en-suite and shared bathroom facilities.

Ward 11 was made up of two bays with patients having access to shared bathroom facilities.

There was a feeding room available for patient use, which provided patients with a private room should they wish to feed their baby away from other patients/visitors.

Sensitive support could be provided at a difficult time, when parents were grieving the death of a baby. A private room with double sleeping arrangements and fairly comfortable surroundings was available, where parents could spend as much time as they required with their baby during the bereavement process. The health board told us that they were in the process of appointing a specialist bereavement midwife to support parents through this difficult time.

Patients who required emergency surgical intervention (such as caesarean section) were transferred to maternity theatres which were situated next to the labour ward.

We received some comments from birthing partners who raised an issue regarding the lack of toilet facilities whilst supporting their partner during labour. The nearest facilities were on the ground floor of the hospital. Birthing partners commented that this meant their partners could possibly be left without family support during labour. Staff told us that such facilities previously existed, but they had been removed to allow room for the Alongside Midwifery Unit.

Improvement needed

The health board should consider appropriate toilet facilities for birthing partners during labour.

Patient information

We found that there was some information available for patients on the ward, displayed on notice boards. Information included both antenatal and postnatal advice. We also saw information provided in a postnatal pack given to patients as they leave the ward.

Communicating effectively

Patients confirmed in the questionnaires that they were given the option to communicate with staff in the language of their choice. There was a loop system for patients with hearing difficulties.

We saw that the wards had Patient Safety at a Glace Boards[4], which were not visible to visitors.

Patients who completed a questionnaire told us that staff had talked to them about their care to help them understand what was happening to them.

We spoke to a newly appointed consultant midwife who appeared to be enthusiastic, motivated and knowledgeable and was employed to improve communication between midwifery and obstetric staff teams across the health board, and promote best practice and support midwifery colleagues. The full impact of this role was yet to be determined, however, the feedback from staff was that it was a positive role in engaging staff across all areas to encourage multidisciplinary working.

Timely care

We spoke to a number of staff during the inspection and received eight completed staff questionnaires. Many staff told us that whilst they were committed to providing timely care, they were often unable to meet all the conflicting demands on their time at work. Further details regarding staffing and resources is explored within a number of sections within the report.

[4] The Patient Status At A Glance board is a clear and consistent way of displaying patient information to staff within hospital wards.

Two patients we spoke to told us that they had to wait some time after requesting pain relief, but explained they understood that staff were busy with other patients. This meant that some patients, due to staff availability, may not have received pain medication in a timely way.

Individual care

Planning care to promote independence

Patients and their partners told us that they were fully involved in all the decisions regarding their baby's birth and the immediate after care of their baby. We observed that the AMU offered a birthing pool, which was an area of good practice.

People's rights

Listening and learning from feedback

The NHS Wales Putting Things Right[5] process was not displayed for patients, neither were there contact details for the Community Health Council for those patients who may wish to have support to raise a concern or complaint about their care and treatment.

We saw that patient experiences were obtained and shared with staff through a monthly newsletter. We found this provided staff with a patient perspective of their experience.

Staff we spoke to confirmed that they would aim to deal with any complaints received from patients whilst on the ward, to help resolve any issues quickly. Senior staff told us that any formal complaints received would be dealt with via the Putting Things Right Process.

[5] Putting Things Right are the arrangements for managing concerns (complaints) about NHS care and treatment in Wales.

Improvement needed

The health board must display information regarding Putting Things Right, to support patients who may wish to raise a concern or complaint, including displaying the contact details for the Community Health Council.

Delivery of safe and effective care

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

Whilst we identified that staff were working hard to prioritise patient care, we were not assured that the service could be sustained in a safe way. This was because significant staffing pressures were impacting on the ability of staff to carry out essential duties such as audits, incident reviews and mandatory training.

The health board is required to address a number of issues to ensure it is able to provide a safe and effective service for patients, and to support the health and wellbeing of staff.

Safe care

Managing risk and promoting health and safety

Entry onto wards 10 and 11 was gained via an intercom system. The labour ward had its own intercom system for patients to allow access directly into this area. We observed staff politely asking visitors the reason for their visit before allowing them to proceed. It was a concern that during our inspection we were left unattended for a period of time after initially being granted access to wards 10 and 11, and staff did not challenge our presence.

We saw that there were some areas where equipment had been left in corridors, such as trolleys outside the theatres. Whilst this did not inhibit safe movement, it meant that the corridors were cluttered. We also found mats on the floor of the AMU that could potentially be a trip hazard as they were not safely secured. There was also no clear secure entry for women into and out of the birthing pool.

We saw that relevant risk assessments had been completed as part of the patient admission process to hospital.

Improvement needed

The health board must ensure that access to the wards is securely maintained for the protection of staff and patients.

The health board should ensure that the mats within the birthing suite in the AMU are not a trip hazard to both staff and patients.

The health board should ensure that the entrance into and out of the birthing pool is safe and secure.

Infection prevention and control

We found that the clinical areas were clean and tidy. Patients who completed an HIW questionnaire and patients we spoke to told us that they thought the wards were clean and tidy.

We saw that personal protective equipment (PPE) was available in all areas; however, we noted that there was low stock on ward 11.

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. We observed staff washing their hands appropriately and using gloves when needed. We also observed that patient beds were cleaned and wiped down after each patient use.

We saw that a health board infection control audit had been carried out in September 2018 which highlighted a number of areas for improvement. We noted that some of these improvements had been addressed and some remained outstanding. However, an action plan was in place to address the remaining actions.

We did not see any evidence of local ward based infection control audits or checks being undertaken. Staff told us that such audits, which included hand hygiene and environmental checks, had been carried out by ward staff previously, but had not been completed since the beginning of the year. We were told that there was an expectation that these should be completed on a weekly basis. Staff told us that due to staffing pressures and time constraints, patient care was prioritised. As a consequence there was no information for patients regarding infection control rates, or compliance with best practice hand hygiene, as this information had not been collated. A recommendation is made

about this within the Quality of Management and Leadership section of the report.

Not all staff who completed a HIW questionnaire had received infection control training within the past 12 months. Staff we spoke with told us that accessing training proved to be difficult due to staffing pressures, meaning that they would often be taken off training courses, or courses would be cancelled due to clinical care taking priority. A recommendation about this is made within the Quality of Management and Leadership section of the report.

Improvement needed

The health board must ensure that personal protective equipment stock levels are maintained sufficiently at all times to support staff in undertaking their roles.

Nutrition and hydration

Patients who completed a questionnaire, and those who spoke to us, told us that they had time to eat their food at their own pace and that they had access to water. The ward staff also had food tokens to obtain hot food for women when it was unavailable on the wards. This, along with the provision of sandwiches, gave patients some element of choice when requiring meals out of normal meal service times.

Medicines management

Overall, we found arrangements in place for the safe management of medicines used in the clinical areas we visited.

We saw that most medicines were being correctly and securely stored. However, we found that the fridges for storing medicines were not lockable in any clinical area. The refrigerator temperature was also not checked and monitored daily to ensure the optimum temperature was maintained for the storage of refrigerated medicines.

We observed that the storage of controlled drugs was secure, as were the drug trolleys. Whilst we saw that checks had been carried out and recorded correctly with regards to the controlled drugs, they were not conducted consistently on a daily basis.

We looked at a sample of medication records and saw these had been completed correctly. We observed part of a medication round on ward 10 and

found that appropriate checks had been carried out by staff to support safe administration of medicines.

Improvement needed

The health board must ensure that medication fridges are lockable and are kept locked when not in use, and that staff record the temperature of the fridges on a daily basis.

The health board must ensure that controlled drug medication checks are carried out consistently on a daily basis.

Safeguarding children and adults at risk

As described earlier, security measures were in place to protect patients within the ward/units. We saw that babies were fitted with tags whilst on the ward for their protection.

Staff had access to a safeguarding lead who could provide advice and support on safeguarding issues. The safeguarding process was described in detail, demonstrating a multidisciplinary approach between services when dealing with safeguarding issues.

Medical devices, equipment and diagnostic systems

Staff reported that there was a lack of some equipment to enable them to carry out their duties in a timely manner. Such items included sonicaids[6], cardiotocography[7] (CTG) monitors and blood pressure monitoring machines. We observed, and staff told us, that they often spent time looking for equipment which decreased the amount of time they were able to be spent with patients.

The inspection team considered the arrangements for the checking of resuscitation equipment on ward 10, ward 11 and labour ward.

[6] A hand-held device for fetal monitoring

[7] A machine used to record the fetal heartbeat

We found that records had been maintained of checks carried out by staff on the equipment to be used in a patient emergency i.e. resuscitation trolleys. However, we found that these had not always been carried out on a daily basis as required. The lack of regular, consistent checks meant that there was a risk of the resuscitation trolleys not being sufficiently stocked with equipment/medication for use in the event of a patient emergency. It was disappointing to find that this specific issue had also been highlighted during a recent HIW inspection in the same hospital, and that the learning had not been shared to ensure that appropriate measures had been put in place.

Our concerns regarding this issue were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The health board must ensure that there is sufficient equipment available to staff to allow them to carry out their duties in a timely manner.

Effective care

Safe and clinically effective care

We found a committed and dedicated team of staff who, under considerable pressure, had to prioritise the direct and immediate needs of patients over other practice areas.

On the basis of discussions with a number of staff across the directorate and evidence collated, we were concerned about the ability of staff to deliver care in a safe and effective way as a result of staffing issues.

We found that the directorate was unable to consistently staff all shifts with the required number of both qualified and non-qualified staff. Staff were often working long hours over and above normal shifts to help cover these shortages. Concerns were also raised as to whether there was always the appropriate mix of skills and experience available during all shifts due to the availability of staff.

Whilst we observed staff effectively prioritising clinical need and patient care, we found that this had a potential impact on the sustainability of the service. Examples included the inability of staff to complete identified training, ability of

staff to appropriately review incidents and concerns (via Datix[8]) in a timely manner, and local ward audits not being carried out due to clinical priorities.

We also had concerns about the sustainability of working arrangements within the service, and the impact that these arrangements may have on the health and well-being of all staff. During the inspection a number of staff presented to the inspection team concerned about their ability to provide care and treatment to patients in a safe manner. This was as a result of long term staffing issues, including both staff shortages and a reliance on the willingness of staff to work hours above and beyond normal working shifts, which has the potential for judgements to be impaired in staff who are fatigued. We also noted that a number of staff presented to the inspection team in a highly emotional and fragile way, emphasising our concerns for their health and well-being.

We were concerned about the potential risk to the safety of patients. This is because we did not feel that the resilience of the maternity department, specifically ward 10, ward 11 and labour ward, was sufficient to maintain patient safety if action was not taken to address the above issues.

Our concerns regarding the above were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Quality improvement, research and innovation

We found that the maternity service was in the middle of substantial change. Maternity services across the health board were in the final stages of being reconfigured. From March 2019 The Royal Glamorgan Hospital is to provide midwife lead care only, with consultant lead care being provided at Prince Charles Hospital. As a consequence of the reconfiguration the health board were recruiting into a variety of new posts, such as a bereavement midwife, a risk and governance midwife and consultant midwife. These appointments were being made with a view to improving the patient experience, but to also improve processes and procedures for the safety and wellbeing of staff and patients. We found that the health board was at the start of a change programme, and new processes were currently being embedded.

[8] An electronic management system for recording and reporting incidents and concerns.

Information governance and communications technology

We saw that patient records were kept securely to help prevent unauthorised access.

Record keeping

Overall we found patient records had been well maintained, were clear and completed in a timely manner.

We considered a sample of five postnatal patient records on ward 10. We saw that pain management had been scored and action taken and escalated where necessary. Appropriate risk assessments, including those for deep vein thrombosis, had been completed.

We found, however, in some patient records where dates had not always been included on every page, and some pages where patient identification stickers were not always used.

Improvement needed

The health board must ensure that patient records include appropriate patient identification labels and dates on each page.

Quality of management and leadership

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

We were concerned to find that there were issues requiring improvement spanning across the service with regards to communication, culture, training, leadership, staffing and multidisciplinary engagement.

A significant concern was that most staff felt that the organisation would not take action following an incident or concern being raised, and lessons would not be learned or shared across the service.

We recognised, however, that the health board had very recently implemented a new governance process around reporting and investigating concerns, and this was at an early stage of being embedded.

A robust governance process regarding ward audits must be demonstrated by the health board, to support the delivery of safe and effective care.

We found that the significant staffing issues were linked to a variety of concerns in respect of the service being able to provide safe and effective care in a consistent manner.

For the health and well-being of staff, and to ensure the service is able to provide safe and effective care to patients, the health board is required, as a priority to take action to address these issues.

Governance, leadership and accountability

It was clear during the inspection that maternity services across the health board were under significant pressure, with concerns and incidents having

being highlighted publically. The directorate had made some recent appointments to strengthen and support changes within the service, but most changes to processes and procedures were at an initial stage and yet to be fully embedded.

Governance

We saw that the service was in the process of implementing a number of regular meetings to support newly embedded processes and procedures, with a view to improving services and to strengthen governance arrangements. Such meetings included a maternity assurance group, which met on a weekly basis. We saw an action plan relating to the maternity service which highlighted areas for improvement including workforce, training, incident reporting, organisational design and service improvements. Ratings were applied to improvements to highlight where action needed to be taken as a priority, and we saw timescales were applied for completion of targets.

We also saw a maternity monthly score card which had information relating to clinical performance. We were told that this information was provided to the health board's quality and patient safety committee on a quarterly basis, which would inform the health board‘s risk register. A dedicated maternity risk register was in the process of being developed. However, the evidence captured during our inspection, including discussions with staff, did not provide assurance that themes and trends across the directorate were being identified and addressed.

Communication

We found there was good, visible leadership directly on the wards, and staff told us they felt supported by the ward managers and shift co-ordinators. Midwifery staff also told us that there was good interaction between the ward staff and the anaesthetic team who were actively engaging in multidisciplinary work and supporting the ongoing changes to the service.

Staff who completed an HIW questionnaire described communication between senior managers and staff as being sometimes, or never effective. Staff we spoke to during the inspection provided examples of where they had found out about service redesign through social media or from colleagues outside of the directorate.

We found that the service was attempting to make changes and improve communication with a monthly newsletter, which provided both clinical and non-clinical information to staff. We also saw the first edition of a weekly update to staff providing information and feedback, including a section on 'you said, we did', to reach out to staff to help inform them of changes they were making in

response to staff suggestions. However, based on the feedback from staff, we found that communication was in need of further improvement, especially with regards to the significant changes and high levels of pressure currently affecting the service.

Incident reporting and learning

Whilst the health board had used Datix for around 10 years, they had recently implemented a new governance process for the reporting of incidents though the system. This was with the intention of ensuring that all incidents and concerns are dealt with appropriately, including having a level of scrutiny to ensure that lessons are learned and shared with staff to prevent any similar incidents reoccurring. The health board had recently appointed a new person in the role of risk and governance midwife to lead the process. The process included appropriate steps that needed to be taken to address and review any incidents or complaints raised, and the allocation of timescales for actions to be completed.

Whilst staff either agreed, or strongly agreed that the organisation encouraged them to report near misses or incidents, the response as to whether they believed the organisation would take action to ensure they did not happen again was mixed, with some disagreeing that any action would be taken. It was also of concern that five staff who completed a questionnaire told us that they either agreed or strongly agreed that the organisation blames or punishes people who are involved in errors, near misses or incidents, with only one person agreeing that the organisation would take action. Staff we spoke to echoed these responses, with some reporting there to be a blame culture resulting in individuals being apportioned fault.

We received a similar response from staff in relation to learning from incidents. Staff we spoke to told us that they did not receive any feedback from incidents that occurred across the service with a view to sharing learning. Staff told us that whilst they received feedback when they had been directly involved in an incident, they felt this was more of a punitive process, rather than as a way to improve.

Staff also told us that as part of the new process they would be allocated Datix incidents to review. Depending on their seriousness, some of these would be allocated to senior members of the ward staff. The new process had allocated timescales for completion of these reviews. Staff told us that they found it very difficult to be able to complete these within the timescales due to staffing pressures. We were told that some staff did not have any non-clinical time, and therefore were unable to complete these reviews within a normal working shift.

This is an important part of the review process, to help identify how and why incidents or complaints have occurred, with a view to learning and prevention to support the delivery of safe and effective care.

Audit activity

With the exception of the health board annual infection control audit, we were unable to see that any audits on the ward had been carried out. Staff we spoke to told us that audits such as hand hygiene, ward round compliance, environment, baby band monitors and induction of labour used to be completed, however, these had not been undertaken for a number of months. Staff explained that this was due to staffing pressures and the need to prioritise patient care.

It was unclear what processes were in place to ensure the health board had oversight of audit activity carried out on the ward. Consequentially, it was therefore unclear what action had, or had not been taken by the health board to address that these had not been undertaken. We were concerned about the overall governance arrangements in ensuring regular and meaningful audit activity is carried out, in supporting the delivery of a safe and effective service.

Working environment

During our inspection we had the opportunity to speak to a number of staff across the directorate, employed in a variety of roles. We were concerned to find that there was an overall disconnect between professional disciplines within the workforce. We did not find that this was isolated to one particular area, level of seniority, or part of the workforce. It was clear from our discussions that there was a lack of trust, poor communication and lack of confidence in senior leadership. Staff told us that they felt undervalued and unappreciated and as previously mentioned, commented that they believed they were working in a punitive environment. As a consequence, we found that staff morale was very low. Senior members of staff we spoke to told us they were aware of the concerns, and were working hard to address these issues. They gave one example of organising multidisciplinary training events to encourage positive team working across the service.

Whilst we received positive comments from staff about the support and engagement from the anaesthetic team with the midwifery team, comments provided by staff about some obstetric staff engagement was less positive. We were told that there was not always a willingness to take part in multidisciplinary events, such as training and meetings. It was positive to note, however, that some obstetric staff had engaged positively with the newly appointed consultant midwife in supporting patient reviews.

We also had sight of the obstetrics and gynaecology consultants meeting minutes produced in September. It was disappointing to find that there was limited reference to the action plan identified as part of the overall service improvements, neither was there any real reference to clinical risks within the service. It is unclear where this information is discussed and actions appropriately taken.

Improvement needed

The health board is required to provide HIW with details of the action taken/to be taken to ensure that communication channels are clearly defined so staff are fully informed about information or changes that impact on them and their work.

The health board is required to provide HIW with details of the action taken/to be taken to ensure that appropriate support and feedback is provided to staff in the aftermath of any concerns/issues raised, in relation to the delivery of safe and effective care to patients.

The health board is required to provide HIW with details of the action taken/to be taken to ensure that staff responsible for reviewing Datix incidents have the time and resources to be able to do so within agreed timescales.

The health board is required to provide HIW with details of the action taken/to be taken to ensure that appropriate audits are undertaken on the wards to support the delivery of safe and effective care to patients.

The health board is required to provide HIW with details of the action taken/to be taken to ensure multidisciplinary working is embedded for the well-being of staff and patients.

Staff and resources

Workforce

As previously mentioned within the report, we found that the service had significant staffing issues. A review of staff rotas leading up to, and post the inspection, demonstrated that the service was unable to meet the required number of staff on every shift on a regular basis. Staff told us that this was, and had been ongoing for a long period of time. Staff who completed a questionnaire and those we spoke to told us that there was only sometimes, or never enough staff to enable them to do their jobs properly.

Discussions with senior managers demonstrated that they were very much aware of the staffing issues, and were attempting to address the problem, including taking the following actions:

- Rolling programme of recruitment of midwives
- Paying overtime to staff to encourage them to work additional shifts
- Midwives being brought in from non acute areas, such as antenatal clinics and the community, to support the acute areas
- Staff from Prince Charles Hospital being asked to cover shifts at The Royal Glamorgan Hospital.

However, we felt that the limited availability of staff had the potential to impact on the ability of the service to continue to provide safe and effective care. Our concerns regarding the sustainability of the service were dealt with under our immediate assurance process, as outlined in the safe and effective care section of the report. Details of the immediate improvements we identified are provided in Appendix B.

Appraisal and supervision

Senior managers and ward staff confirmed that there was a staff appraisal process in place which assisted with determining ongoing training needs. We found that a large number of these had been completed this year.

We found that the health board did not have in place a sufficient number of supervisors to provide clinical supervision for midwives. We were told that the health board was in the process of trying to embed a new model for clinical supervision, to provide support and guidance to staff. The health board must ensure that the arrangements for providing clinical supervision to midwives are sufficient to meet the needs of staff.

Training

Staff training records were maintained by the practice development midwife. Whilst we found that the practice development midwife was working very hard to collate this information and manage, co-ordinate and monitor staff training,

the information was limited and we were not assured that all staff had received the relevant mandatory training. We also found that staff were not always able to be released from their clinical duties to attend mandatory/other relevant training due to staffing issues. We were told that PROMTP[9] training had been cancelled on a number of occasions due to staffing pressures. We also found poor compliance with cardiotocography (CTG) training. Whilst the practice development midwife had put together a programme of training for staff, staffing pressures often meant that staff had been unable to attend. The training programme put in place meant that a majority of staff should receive the mandatory cardiotocography training by February 2019, dependent upon staff availability.

Senior managers told us that they were in the process of collating an all staff training matrix to determine the training needs of staff, and that this was ongoing. It is crucial that the directorate has a thorough understanding of the knowledge, skills and competencies of their workforce to ensure they are able to provide safe and effective care.

We recognised the work carried out by the practice development midwife in supporting newly qualified midwives into the service, including the development of the prep to practice programme passport. This supported newly qualified midwives in their first year of practice by developing and underpinning the competencies gained during training. We found this an area of noteworthy practice.

Improvement needed

The health board is required to describe how it will ensure that its workforce:

- Maintains and develops competencies to meet patients' needs
- Attends induction and mandatory training programmes

The health board must ensure that the provision of clinical supervision is

[9] PROMPT (Practical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working

appropriate to the number and need of their workforce.

4. What next?

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

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

The improvement plans should:

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

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

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

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

5. How we inspect hospitals

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

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No concerns were identified on the inspection that were required to be addressed immediately.			

Appendix B – Immediate improvement plan

Hospital: The Royal Glamorgan Hospital

Ward/department: Ward 10, ward 11 and labour ward

Date of inspection: 15 - 17 October

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

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to ensure that resuscitation equipment/medication is always available and safe to use in the event of a patient emergency on Ward 10, Ward 11 and Labour Ward. The health board is required to provide HIW with details of the action taken to ensure that resuscitation equipment/medication is always available and safe to use across all other wards and departments across the health board.	Standard 2.6 and 2.9	Feedback meeting held with staff including support staff the following day Notes of the meeting taken & shared with all staff via e mail. Review of current process to check equipment undertaken by Senior Midwife, Ward Manager and clinical midwife. Process stream lined. Band 7 Coordinator identified as the person responsible on Labour Ward to	Senior Midwife Band 7 Co coordinators	18 October 2018 22 October 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		ensure all resuscitation equipment has been checked on a daily basis. Ward Manager identified as the person responsible for Ward 10 & 11	V Box Ward Manager	22 October 2018
		Senior Midwife to be provided on a weekly basis evidence of 100% compliance with daily checks	V Box Ward Manager	29 October 2018
		Fortnightly on the spot audit to be undertaken by the Ward Manager to ensure new process is embedded.	V Box Ward Manager	5 November 2018
		Audit findings to be reported to monthly clinical Governance meeting.	V Box Ward Manager	19 November 2018
		Discuss actions taken with Jane Phillips HoM Support ABMU to ensure actions taken are shared & implemented in PCH	Senior Midwife	24 October 2018
The health board is required to provide HIW with the actions it intends to take to safeguard the sustainability of the service.	Standard 2.1 and 7.1	Safety Huddles are held at shift handover where potential risks, staffing levels and actions being taken, to maintain safe, effective services are shared with the	Assistant Director Surgery/Maternity Services	29 March 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the actions it intends to take to ensure the health and wellbeing of staff is maintained and protected.		multidisciplinary teams, with clarity on the mitigating actions being taken. Assurance meetings regarding the safety of the service are held weekly, included within which are with Senior Midwives, Clinicians, Directorate Managers and Patient Safety team members. Each month divides into the following governance arrangements. Weeks 1 & 2 the Maternity Services Operational Group meets where issues including safe staffing levels, locum usage is monitored. There is a contingency plan in place, supported by escalation procedures, when staffing levels are impacted upon, either because of staff absences or as a result of high patient acuity levels. Services are limited in accordance with the Escalation Policy when safe staffing levels are not achieved, including		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		support from neighbouring Health Boards to accept patient flows on a case by case basis.	DoN	
		Week 3 Executive Maternity Assurance Group, Chaired by the Executive Lead for Maternity, Professor Angela Hopkins. Next meeting 30th October 2018		30th October 2018
		Week 4 Strategic Maternity Improvement Board, with external stakeholders, including WG, DU and invitation extended to HIW. Chaired by a former Executive Nurse Director in NHS Wales, Denise Llewellyn. Inaugural meeting November 6th 2018.	Retire Ex Nurse Director	6 November 2018
		The new graduate midwives 8.8wte commenced work, preceptorship period of 6 weeks ongoing.	Senior Midwife	8 October 2018
		After a robust induction process these midwives will commence clinical duties.	Senior Midwife	19 November 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		A further 4.84 wte Band 6 midwives have been recruited and after Pre Employment checks and an induction period will commence clinical duties.	Senior Midwife Senior Midwife	3 December 2018
		Further interviews for midwives took place on 24 October 2018 with an additional 1.64 wte Band 6 midwives appointed	HoM Support ABMU	3 December 2018
		There continues to be a rolling advert on NHS for midwives.	Senior Midwife/ HR Business Partner	March 2019
		From 19 November 2018 there is a plan to offer both graduate and experienced midwives to be re deployed to RGH		19 November 2018
		Staffing levels have improved in RGH over the past 2 weeks due to a reduction in the sickness rate. Sickness levels are being analysed to identify trends in both short and long term sickness. There ongoing sickness management and support available to encourage staff back to	DoN Senior Midwife	22 October 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		work The Health Board have agreed to pay double pay for an 8 week period to all staff who work overtime shifts. This is being closely monitored with agreed criteria to ensure risks are minimised for staff to work excessive hours. Health Board have agreed to provide 24/7 Ward Clerk cover to assist in non-clinical activities previously being undertaken by clinical staff Two wte midwives have been temporarily redeployed from the Community to work in RGH Antenatal clinic staff are providing Day Assessment cover until further notice. When necessary Tier 1locum doctor cover by night is obtained to release the Senior Clinical Midwife to work as a clinical Midwife.	 Senior Midwife Community Deputy Directorate Manager Executive Team DoN	 1 October 2018 30 November 2018 24 September 2018 24 October 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		The Health and Wellbeing of staff is being taken seriously. The Executive team and Directorate Team including HR visit the clinical area on a weekly basis. Chief Executive Officer has held meetings where all members of the multidisciplinary team are invited to attend The Executive Nurse Director holds two weekly meetings where all members of the multidisciplinary team are invited to attend. Communication updates are provided to all staff on a weekly basis including “You said, We Did” following suggestions from the Lead Executive for maternity services. Occupational Health have agreed to expedite maternity staff in both recruitment process and sickness management.	Deputy Directorate Manger HR Business Partner Clinical Psychologist. Deputy Directorate Manager	Weekly Weekly

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		There is a plan to direct any member of staff to a Clinical Psychologist if they wish to discuss any issues both professionally and personally.	Clinical Director	
		Where appropriate staff from neighbouring Health Boards have been recruited in for additional support.	Clinical Director	
		RCM providing regular site visits	Clinical Director	
		Locum advert for locum Consultant posts – Interviews 26th October 2018		26th October 2018
		Permanent Consultant posts being submitted to RCOG for approval		9th November 2018
		Associate Clinical Director posts being advertised and appointed for labour ward and gynaecology		9th November 2018

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Lead roles within the department to be agreed within Consultant team		26th October

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): Angela Hopkins

Job role: Executive Director of Nursing, Midwifery and Patient Care

Date: 26 October 2018

Appendix C – Improvement plan

Hospital: The Royal Glamorgan Hospital

Ward/department: Ward 10, ward 11 and labour ward

Date of inspection: 15 - 17 October 2018

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 should consider appropriate toilet facilities for birthing partners during labour.	4.1 Dignified Care	The service will review the facilities in and around the birthing areas to identify a suitable toilet. Currently the only toilets available are actually in the ward – which would seem an important consideration re: Dignity of other women on the ward. Partners will be offered to use the facilities in the delivery room areas if birth is imminent. The nearest facilities will be explained to	Senior Midwife for RGH	30 April 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		birthing partners when they are in the unit. In March 2019 when the services move to Prince Charles Hospital, the birthing centre in Royal Glamorgan will have additional facilities for birthing partners due to the freeing up of the current clinical areas. The women's experience midwife will ensure that there is opportunity for all who use the service to comment on the environment of care and facilities provided. all feedback will form part of the information shared via the directorate governance meetings		
The health board must display information regarding Putting Things Right, to support patients who may wish to raise a concern or complaint, including displaying the contact details for the Community Health Council.	6.3 Listening and Learning from feedback	Information will be placed in every ward and clinic advising women and their families how they can raise a concern. Information about the community health council and leaflets advertising the services provided will be displayed alongside 'Putting Things Right' The recently employed specialist	Women's experience midwife	December 31 2019 December 31

Improvement needed	Standard	Service action	Responsible officer	Timescale
		midwife for Women's Experience will be responsible for ensuring women's experience both positive and negative is obtained and subsequently acted upon. The Health Board has a Patient Advice and Liaison Service (PALS) team who will provide additional support and visibility in the maternity wards to gain 'real time' feedback from women & their families. Feedback currently being monitored via social media will be shared with the maternity team.		2018 Completed Nov 2018 Commenced December 17 2018 December 14 2018
Delivery of safe and effective care				
The health board must ensure that access to the wards is securely maintained for the protection of staff and patients. The health board should ensure that the mats within the birthing suite in the AMU are not a trip hazard to both staff and patients. The health board should ensure that the entrance into and out of the birthing pool is safe	2.1 Managing risk and promoting health and safety	The unit has twin sets of double safety doors at the entrances, with an air lock area between. One twin set of doors closes and locks, before the second twin set of doors can be released, thereby, providing a safe entry and egress from the wards. New signage has been placed at the entrance and exits to advise all visitors not to allow other	Senior Midwife for RGH	Completed December 12 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
and secure.		visitors to enter the ward without using the visitor's intercom system to gain permission to enter and for the first set of doors to be released from within the maternity unit. A safety drill will be undertaken to test the system, the outcome of the drill will be fed back to all staff.	Senior Midwife for RGH	31 December 2018
		The birthing mats have been removed and will be accessed as and when required.	Senior Midwife for RGH	Completed December 12 2018
		Staff have been reminded to ensure that, in addition to closure of the curtains into the MLU area and the pool room, that the door into the pool room is also closed when in use to maintain the highest level of privacy. This will be continually monitored by the labour ward sister and the senior midwife and practice challenged where compliance is not achieved.	AMU lead / Senior Midwife for RGH	Completed December 12 2018
		Measures already in place:		
		Anti-slip flooring for use in areas where		

Improvement needed	Standard	Service action	Responsible officer	Timescale
		there is likely to be water underfoot – similar to changing rooms in swimming pools Women use a slip proof step to get into the pool aided by their birthing partners and their midwife To exit the pool the women step from the pool onto the seat in the pool and onto the step assisted by the midwife and birthing partner All staff providing care are trained in the use of the pool including safety of the women and emergency evacuation from the pool In addition, the service will explore the option of using a step which has a handle attached to it.		
The health board must ensure that personal protective equipment stock levels are maintained sufficiently at all times to support	2.4 Infection Prevention and Control (IPC) and	Additional personal protective equipment stocks have been ordered for all areas and staff have been reminded	Senior Midwife	Completed December 12 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
staff in undertaking their roles.	Decontamination	of the importance of wearing these during procedures. Daily checking process introduced to include ensuring stock levels of the equipment are maintained Staff have been made aware that additional supplies of personal protective equipment is available from the hospital bed managers.	Ward sisters Senior Midwife for RGH	Completed December 12 2018
The health board must ensure that medication fridges are lockable and are kept locked when not in use, and that staff record the temperature of the fridges on a daily basis. The health board must ensure that controlled drug medication checks are carried out consistently on a daily basis.	2.6 Medicines Management	The ward staff have been requested to ensure medication fridges are locked at all times. This will be included in the senior midwives monthly assurance audits. The daily recording of the temperature of the drug fridges has been included on the daily checking record sheet. In addition, the fridges are also fitted with an alarm for when the temperature goes above the appropriate level to alert staff. The protocol for escalation should this	Ward sisters Senior Midwives	Completed December 12 2018 January 31st 2019 Completed December 12 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
		issue arise is being recirculated to staff.		
The health board must ensure that there is sufficient equipment available to staff to allow them to carry out their duties in a timely manner.	2.9 Medical devices, equipment and diagnostic systems	Equipment requirements have been obtained from all clinical areas and orders placed. Early delivery has been requested to address this issue. The responsibility and process for reporting and replacing broken equipment has been communicated again to the ward sisters.	Head of Midwifery Ward sisters	Delivery dates within the coming weeks, completion likely February 2019 Completed December 12 2018
The health board must ensure that patient records include appropriate patient identification labels and dates on each page.	3.5 Record keeping	Staff have been reminded that to support safe care and meet NMC requirements patient record labels must be used on every piece of documentation that relates to the patient. This will be monitored via the monthly assurance audits, which the midwives	Head of Midwifery	Completed 13 December 2018 1st audit completed January 31

Improvement needed	Standard	Service action	Responsible officer	Timescale
		will be engaging in as part of a learning and peer review process, and this will also be included within the annual record keeping audit. Findings of the audits will be used in feedback to staff in order to maintain standards of record keeping. These will be reported at the midwifery professional forum and audit meetings in 2019.		2019 End of December 2019
Quality of management and leadership				
The health board is required to provide HIW with details of the action taken/to be taken to ensure that communication channels are clearly defined so staff are fully informed about information or changes that impact on them and their work. The health board is required to provide HIW with details of the action taken/to be taken to ensure that appropriate support and feedback is provided to staff in the aftermath of any concerns/issues raised, in relation to the delivery of safe and effective care to patients.	Governance, Leadership and Accountability	Weekly staff briefing sent out from the Directors to ensure all communication is shared. This includes feedback on the actions taken by the UHB following the monthly staff briefings or during visits to the unit where staff raise issues or advise on solutions. Use of the 'You Said: We Did' attachment to the weekly written communications from the Director of Nursing, Midwifery and Patient Care has proved very useful in identifying progress and resolution on		Completed December 7 2018

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken/to be taken to ensure that staff responsible for reviewing Datix incidents have the time and resources to be able to do so within agreed timescales. The health board is required to provide HIW with details of the action taken/to be taken to ensure that appropriate audits are undertaken on the wards to support the delivery of safe and effective care to patients. The health board is required to provide HIW with details of the action taken/to be taken to ensure multidisciplinary working is embedded for the well-being of staff and patients.		issues raised. The UHB has ensured there are regular face to face meetings with the Board members, which includes visiting staff out of hours and when the executive is on call for the whole Health Board. Occupational Health services have provided easy access for wellbeing support mechanisms. Clinical psychology support is available and open to all staff – this has been communicated via managers. The senior midwives will monitor the incidents in their units. The senior midwives have received training and support to manage these. Additional support to manage the backlog of incidents has been given with assistance of a member of staff on	Senior Midwives Senior Midwives Head of Midwifery	Completed October 31 2018 Completed October 2018 March 31 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		secondment from another Health board until the end of the financial year.		
		A new assurance audit tool has been developed with a requirement to undertake monthly assurance audits in each of the clinical areas.	Senior Midwives	To commence January 31 2019
		The findings will be shared at the monthly professional forums and via audit in relation to any medical findings requiring sharing.		January 2019
		The UHB has introduced PROMPT and is well ahead of the Welsh Risk Pool expected timescale for implementation.	PROMPT lead for Health Board	Review in January 2019
		The Senior Midwifery team are attending multidisciplinary handover meetings to gain assurances that the handovers include the necessary information to support safety and management of activity for the shift. This will continue on a regular basis throughout the year. Findings of the	Senior Midwives	

Improvement needed	Standard	Service action	Responsible officer	Timescale
		observation's will be shared at the audit and midwifery professional meeting The Health Board has funded and supported the attendance of senior clinical midwives, consultants from obstetrics and anaesthetics to attend the Royal College of Midwives - Labour Ward leadership programme in Dublin. This has evaluated well and the team have returned to the UHB with a planned quality improvement initiative. Maternity services have reviewed the current Quality & Safety structure and have developed a new reporting structure which includes the multidisciplinary team which will ensure robust mechanisms are in place to support Multidisciplinary Team working in the future. This structure was approved at the Maternity assurance Board with Welsh Government	Directorate team Head of Midwifery	Completed December 6 2018 Completed December 4 2018
The health board is required to describe how it	7.1 Workforce	Training levels are being monitored and	Practice	To

Improvement needed	Standard	Service action	Responsible officer	Timescale
will ensure that its workforce: • Maintains and develops competencies to meet patients' needs • Attends induction and mandatory training programmes The health board must ensure that the provision of clinical supervision is appropriate to the number and need of their workforce.		a new training & education forum is being established to ensure there are multi-disciplinary training programmes which reflect the clinical requirement of the service. A training database is now in place for medical, midwifery and support staff training. This ensures up to date monitoring of compliance to achieve 100% standard of completion. Maternity services have just appointed one Clinical Supervisor of Midwives (CSfM) and expressions of interest have been received from other midwives, which will ensure the Welsh Government ratio of CSfM's to midwives is achieved .	Development midwife & Directorate manager Head of Midwifery	commence February 2019 March 2019 January 31 2019

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): Jane Phillips

Job role: Support Head of Midwifery Date: 13th December 2018