Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Neath Port Talbot Hospital / The birth centre / Swansea Bay University Health Board

Inspection date: 22 and 23 October 2019

Publication date: 24 January 2020

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

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

Website: **www.hiw.org.uk**

Digital ISBN 978-1-83933-952-3

Contents

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

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

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Neath Port Talbot Hospital within Swansea Bay University Health Board on the 22 and 23 October 2019. The following was visited during this inspection:

- The birth centre

Our team, for the inspection comprised of two HIW inspectors (one lead), two clinical peer reviewers and a lay reviewer.

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

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

2. Summary of our inspection

Overall, we found that care was provided in a safe and effective manner. Staff within the birth centre demonstrated a clear passion and drive to provide high standards of care to patients, in a dignified and supportive way.

Some areas for improvement were identified, to ensure high standards of care continued to be provided in accordance with national guidance and the Health and Care Standards.

This is what we found the service did well:

- Feedback from patients was very positive about their experience of the birth centre
- The birth centre was clean, tidy and free from hazards
- Staff were committed to providing information to patients to support them making informed choices about their care
- There were regular and consistent checks of equipment within the birth centre to uphold standards
- Staff had good access to training, and were supported to ensure they were able to attend.

This is what we recommend the service could improve:

- Clear communication to staff regarding reporting staffing concerns
- Explore the reasons why some staff feel unsupported following clinical incidents or reported concerns
- Improvements to some patient records in respect of more clear documented notes in relation to patient transfers
- Review of managerial arrangements to ensure there is sufficient support and managerial oversight of services
- Improvements to the electronic clinical dashboard of the unit to ensure standards are monitored and maintained.

3. What we found

Background of the service

Neath Port Talbot Hospital is located within Swansea Bay University Health Board. The health board was created on 1 April 2019, after responsibility for providing healthcare services in the Bridgend County Borough Council area passed from Abertawe Bro Morgannwg University Health Board, to the new Cwm Taf Morgannwg University Health Board. The health board covers a population of approximately 390,000 in the Neath Port Talbot and Swansea areas of South West Wales.

The health board has three acute hospitals providing a range of services; these are Singleton and Morriston Hospitals in Swansea and Neath Port Talbot Hospital in Port Talbot. There are a number of smaller community hospitals and primary care resource centres providing clinical services outside of the three major hospitals.

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 or who are transferred to Singleton Hospital. This is provided should their baby require care from the level of three neonatal intensive care units for the West of Wales region or beyond.

In 2018-19 a total of 5,574 births occurred within the former Abertawe Bro Morgannwg University Health Board. Of these figures, out-of-area births accounted for 535 births.

Women who birth within the health board have the choice of four birth settings. These include a homebirth, Free-standing Midwife Unit (FMU) at Neath Port Talbot Hospital, an Alongside Midwife Unit (AMU) and Obstetric Unit (OU) within Singleton Hospital. All midwife led intrapartum care settings have access to the Obstetric unit when complications arise in labour.

Quality of patient experience

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

We observed polite, friendly and supportive interactions between staff and patients that were delivered in a way that upheld patient dignity.

Breastfeeding support to patients was of a high standard, allowing patients to have home visits and self-refer themselves to the birth centre for additional support if needed.

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

We found the environment to be clean, tidy and welcoming to patients, partners and visitors.

Information should be displayed regarding the Community Health Council (CHC) for advocacy and support.

During the inspection there were very few patients in the birth centre, meaning that direct patient contact with the inspection team was very limited. We were able to see that the birth centre collected patient and family feedback on a regular basis, and we saw this was displayed around the unit.

Patient feedback we saw was very positive and highly complementary of the care, treatment and support provided by staff.

Staying healthy

We saw that a number of patient information leaflets were available in and around the birth centre, for patients and their partners to read. Information and advice regarding flu prevention, smoking cessation, breastfeeding and hand hygiene were all displayed.

Patients were provided with a discharge pack which also included additional information about stopping smoking, including additional sources of support such as the GP or on-line services. Also included in the discharge pack was breastfeeding and bottle feeding information. Relevant information about how to maintain a baby's temperature and safe caring techniques were also included.

The birth centre was UNICEF[1] baby friendly accredited, and we saw a poster advertising this in the main corridor of the birth centre. Staff told us that a maternity care assistant was able to provide a high level of breastfeeding support to mothers, providing breastfeeding workshops during the antenatal period, and support in the birth centre during the postnatal period, as well as supporting patients in the community in their own homes. Staff told us they highly valued the support provided by the maternity care assistant. Patients were able to self-refer themselves onto the birth centre to receive breastfeeding support from staff.

Dignified care

As highlighted earlier, during the time of inspection, there were very few patients on the birth centre. However, we observed polite, friendly and professional interactions between staff, patients and visitors who were there. A notice board displayed thank you cards and comments provided by patients, which were highly complementary of the care provided.

The environment ensured that care was able to be provided in a dignified way. Single and double rooms were available, meaning that partners were able to stay overnight. Some rooms shared bathroom facilities, however we were told that staff would accommodate patients in rooms to try to make sure they had their own facilities.

The birth centre had one birthing pool, and we found this and the other labour rooms were decorated in a homely way. Medical equipment was stored behind curtains to make the rooms feel less clinical and more conducive to a birth centre environment.

[1] https://www.unicef.org.uk/babyfriendly/

There was a small waiting room in the birth centre that was pleasantly decorated and welcoming for patients, partners and visitors to use.

We were told that the birth centre cares for patients who are considered low risk, and any patients would be transferred to an obstetric unit, should there be any indication of risk to either mother or baby. Whilst not having a dedicated bereavement room, staff told us they would be able to appropriately care and support any recently bereaved parents whilst waiting to move to Singleton Hospital for specialist support. The health board had an appointed bereavement midwife who could offer the appropriate support when needed.

Patient information

The birth centre provided tours of the unit, to provide patients with an overview of the facilities and services, to help patients make informed decisions about their care.

Clear information about staff was available for patients. There was a board in the birth centre detailing the staff on shift that day/night. We saw that this was changed and updated at each shift change.

Staff we spoke with were aware of the translation services within the health board and how they could access these, to support patients whose first language may not be English.

Communicating effectively

We observed conversations between staff and patients visiting the unit. We found staff to be welcoming and knowledgeable in their conversations with patients. We looked at a sample of patient records and found there to be clear birth plans documented within them.

We saw that staff on the unit met formally twice daily at shift change over time, in addition to communication throughout the day. This was in order to communicate and discuss patient needs and plans with the intention of maintaining continuity of care.

A consultant midwife holds birth choice clinics, where they are able to discuss birthing options with patients. This includes those patients who may normally sit outside of the normal labour pathway, who may want to have their baby at the

birth centre. An example was provided of patients whose Body Mass Index (BMI)[2] was above what was determined to be within normal ranges, and discussions were held with them to provide them with relevant information to help them make an informed decision.

Timely care

Staff told us they were highly attentive to patient needs, ensuring that their personal, nutritional and comfort needs were met in a timely way. We saw evidence of this within the patient care records we looked at.

We saw there were processes in place to help ensure that patient transfers to an obstetric unit would happen in a timely manner. There was a flow-chart for staff to follow when speaking with the Welsh Ambulance Service Trust (WAST), which included key trigger words to use to highlight the level of urgency. The consultant midwife had recently conducted a review of transfer times from the birth centre, which highlighted that there had been an increase. This information was included in the health boards risk register, highlighting the area of concern and risk to the wider management team. We were able to see that the timings had been clearly communicated to patients, to ensure they were able to make an informed decision about their care.

Individual care

Planning care to promote independence

The birth centre was on the first floor of the hospital, and was accessible via stairs or lifts. Patient parking was available outside the hospital.

The birth centre was clean, tidy and free from hazards, meaning that patients were able to easily walk around in an uncluttered environment.

Double beds were available in the birth centre, meaning that partners were able to stay and provide support to patients and babies during labour and the postnatal period.

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

People's rights

Both staff and patients told us that open visiting was available, allowing the partner, or a significant other, to visit freely.

In a sample of patient records we looked at, patient birth choices were clearly documented, with the risks and benefits clearly outlined, to support patients making an informed decision about their care.

Listening and learning from feedback

Information was displayed in the birth centre relating to the NHS Wales Putting Things Right[3] complaints process, for patients to follow should they have concerns about their care. Staff told us they would aim to deal with any issues raised at source, with a view to resolving them quickly. If they were unable to resolve directly, they would speak with a senior manager for advice and signpost a patient to the complaints process. We did not see any information in relation to the Community Health Council, who are able to provide a support and advocacy service to patients should they wish to raise a concern.

Weekly meetings were held with senior managers within the maternity division from across the health board, including the governance lead and clinical risk midwife leads. These meetings provided an opportunity for information to be shared from across the two health board maternity sites, regarding complaints and clinical incidents.

We were able to see that feedback from patients is actively obtained by the birth centre. Patients were given a questionnaire prior to leaving the birth centre, and they were able to leave it in a box, ensuring feedback could be provided anonymously. Blank cards were also available for family and friends to complete, should they wish to provide feedback. This information was collated on a regular basis and we saw feedback was displayed for staff and patients to see in the birth centre.

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

Improvement needed

The health board must provide information to patients about 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.

Overall, we found that care was provided to patients in a safe and effective way.

The birth centre was clean and tidy, upholding the standards of infection control.

We saw that there were regular checks in place to ensure the environment and equipment remained safe to use.

We observed a good standard of record keeping, with some improvements necessary with regards to patient transfers, to ensure a high standard is maintained.

The health board must ensure that regular birth pool evacuation drills are taking place.

The health board must clarify the process to staff to ensure they are aware of the process for regular testing of the water used in the birth pool.

Consideration should be given to the curtains within patient rooms to ensure they comply with infection control standards.

Safe care

Managing risk and promoting health and safety

We found the birth centre to be uncluttered, clean, tidy and free from any hazards.

We observed there were appropriate measures in place for the safe storage of cleaning equipment, preventing unauthorised access.

The birth centre ensured that babies were secure on the wards by using security mattresses. We saw that these were in use during the inspection. Patients and visitors were required to be buzzed in and out, to help ensure babies remained safe in the birth centre.

We saw appropriate and regular checks were being carried out across the birth centre, to help ensure it remained safe to use. These included checks on the emergency drugs and equipment, the birth pool, infection control arrangements, medication storage temperatures and the overall environment. The outcome of these checks were reported to senior managers on a regular basis to provide an oversight of the activities.

Infection prevention and control

We found the birth centre to be well organised, free from clutter and very clean and tidy.

We saw records to show that the birth pool was cleaned daily, as well as after each use. It was unclear whether regular testing of the water was carried out, and staff were not able to provide a policy or procedure to demonstrate the process.

In each of the rooms, we saw equipment was stored behind curtains, to help provide a homely environment. However, the curtains were not disposable, and were not replaced regularly.

Personal protective equipment was readily available throughout the birth centre for staff to use. We observed staff upholding the standards of being bare below the elbow[4] to uphold infection control standards.

Hand washing and drying facilities were available across the birth centre, together with posters above sinks displaying the correct hand washing procedure to follow as a visual prompt for staff, patients and visitors. Alcohol sanitiser gels were available at the entrance to the birth centre, and located within the birth centre for staff, patients and visitors to use.

A monthly infection control and hand hygiene audit was carried out by a healthcare support workers, to help ensure staff were up to date with their hand

[4] 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.

washing technique, and to ensure the environment upheld infection control standards.

Improvement needed

The health board must:

- Consider whether the use of curtains in the rooms to hide equipment are upholding infection control standards
- Provide HIW with assurance with regards to the process for testing water used for the birth pool. A policy and/or procedure must be made easily accessible to staff and clearly communicated.

Nutrition and hydration

Hot meals were provided by the hospital kitchen, and patients were able to choose what they wanted to eat. Sandwiches were also available to patients should they choose these instead.

The birth centre was able to provide a high level of support to patients who wished to breastfeed. Healthcare support workers, as well as a maternity care assistant were able to provide one to one support on an individual basis, to help ensure babies were sufficiently fed and hydrated.

Patients were also able to admit themselves back onto the birth centre for breastfeeding support. We saw they were also provided with meals during their stay. The maternity care assistant was also able to provide breastfeeding support to patients in their own homes.

Medicines management

We found there were appropriate processes and procedures in place for the safe storage, administration and management of medicines in the birth centre.

Fridges used to store medicines were checked daily to ensure the temperature was within the correct limits for safe storage. Controlled drugs were also stored securely in a locked cupboard. We viewed the records for the management of controlled drugs and found that the information was checked daily and clearly recorded.

We observed that mothers and babies are issued with identification bands, to ensure that appropriate checks can be carried out when administering medication.

The birth centre did not carry out a routine drugs round, being a smaller unit, we found that patients were provided with their medication on an individual basis and in a timely way.

Safeguarding children and adults at risk

A safeguarding midwife was appointed for the health board to provide specialist advice and support to staff with any safeguarding concerns. Staff we spoke with were able to describe the processes and procedures to follow in the event of any safeguarding concerns. All staff who completed a HIW questionnaire told us that they had received safeguarding training within the past 12 months.

As described earlier within this report, security measures were in place to protect patients within the unit. There were intercom systems used at the entrances to areas to maintain safety around people entering the wards. We also saw that babies were lying on pressure mattresses to ensure their safety.

Medical devices, equipment and diagnostic systems

We looked at the arrangements for checking the resuscitation equipment for patients and found there were appropriate processes in place to ensure that the equipment remained safe to use.

We found there to be sufficient supplies of relevant equipment around the birth centre, and staff reported that there were no issues. We were told that issues or faults with equipment were reported to a central health board team and equipment was either repaired or replaced in a timely way.

Equipment was stored safely and securely in the birth centre, preventing unnecessary equipment being left around as hazards.

Effective care

Safe and clinically effective care

In the sample of patient records we reviewed, we were able to see that patients received pain relief in a timely way, however, there was no record to show that any pain assessment tools had been used.

The birth centre had one birth pool, and we saw there were evacuation processes in place, and appropriate equipment was available to support a patient needing

to exit the pool quickly. We were told that evacuation drills normally take place on a monthly basis, however, these had not been taking place recently due to staffing issues.

The health board confirmed that the workforce planning and birth rate plus[5] calculations are based on an intrapartum model of care within the Neath Port Talbot community midwifery team. The community midwifery teams are integral to the service provision in the birth centre.

We were able to speak with a number of community midwives during the inspection, as they form part of the birth centre team, and issues were raised with regards to high sickness levels and vacancies within the team. Whilst we understood community midwives to be an integral part of the service to provide intrapartum shifts and on call, staff expressed concerns about being called into the birth unit to provide midwifery support when the acuity levels increased. Some staff told us that this meant they were often working long hours to cover shifts and complete their work, above and beyond their hours. Some staff told us this had the effect of being unable to carry out their community midwifery duties in a timely way. Some felt fearful they would not be able to carry out their roles effectively, and provide the high level of care they wanted to. This is explored in more detail in the Quality of Management and Leadership section of this report.

Improvement needed

The health board must ensure that:

- A pain assessment tool is used by staff to effectively monitor pain levels.
- Regular evacuation drills are carried out to keep staff up to date with their skills.

[5] https://www.birthrateplus.co.uk/

Information governance and communications technology

Policies and procedures were available on the health board's intranet, and staff within the birth centre told us they were able to access these readily. Community based staff only had access to a computer within the birth centre, with some reporting that this can cause problems with accessing documents. We were told that the health board were currently trialling new IT equipment which would provide community staff with continuous access to a range of health board IT packages, including being able complete and update patient records electronically, away from the birth centre.

Patient records were in a paper format, and we found them to be kept securely to prevent unauthorised access.

Record keeping

We looked at a sample of patient records, and found they were of a good standard. We found them easy to navigate, clear to follow and written contemporaneously.

We found there was good evidence of discussions held regarding patients birth choices. Information included the risks and benefits of their birth choices, and transfer times to the obstetric unit were clearly communicated and documented to patients. These were clearly documented within the patient records we reviewed.

We looked at some records where patients had been transferred out of the birth centre to receive their care at the obstetric unit. We found that the notes did not clearly demonstrate the reasons why. We also did not see that an SBAR[6] had been completed for the transfer of the patient.

[6] A tool used to clearly communicate patient information amongst staff in a clear and concise way under four domains; situation, background, assessment, recommendation (SBAR).

Improvement needed

The health board must ensure that patient records clearly demonstrate the reason for a patient transfer out of the birth centre, and include an SBAR.

Quality of management and leadership

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

We found a committed and dedicated team of staff who were working closely together to provide high standards of care.

There had been a number of personnel changes over the past 18 months, resulting in some instability and uncertainty amongst some staff. Concerns were reported regarding staffing levels, and the support received from management following clinical incidents or reported concerns.

We found improvements could be made with regards to communication with staff, in order to resolve some of the issues raised during the inspection.

Governance, leadership and accountability

In April 2019 two health boards in Wales were reconfigured[7], which resulted in a number of personnel changes across maternity services. Staff reported that this had proven to be a challenging and unsettling time, with many managerial changes affecting the birth centre, with a number of interim positions being in place.

[7] A boundary change in the Bridgend area of South Wales meant that healthcare services in this area were transferred to the newly created Cwm Taf Morgannwg University Health Board. Healthcare services in Swansea and Neath Port Talbot area are provided by the newly created Swansea Bay University Health Board.

A newly appointed matron to the birth centre had been in post for four weeks at the time of inspection. This was a permanent appointment, with the aim of bringing stability to the service. It was recognised by the inspection team that the appointment was at an early stage, however, we discussed where areas for change and development had already been identified, with a view to stabilising and building on the future of the birth centre.

We saw there was a maternity dashboard in place, which is a tool to monitor clinical performance of the unit. This was under development, with much of the information needing to be input manually. The dashboard was not able to produce ratings against local and national standards, which meant the service may not be able to take prompt action when standards are not being met. We were told that this was in the process of being addressed and should be in place by the end of 2019.

We saw there was a maternity risk register, which highlighted the 12 highest risks of the unit. We were told that this was updated every two months, and presented to the health board's quality and safety committee, in order to provide an overview to senior managers of the risks faced by the birth centre.

We saw that regular assurance reports were provided to the senior management team. These were outcomes of ward audits carried out by staff in the birth centre. These included infection control, controlled drugs, staff presentation, environmental and equipment checks.

We found there were clear governance processes in place for the reporting and investigation of clinical incidents. A governance team was in place, and they were responsible for the management of concerns and incidents. We found that the senior management team were provided with information on a regular basis to ensure they were aware of the action being taken to address issues, and to identify themes and trends.

Learning from incidents and audits, alongside areas of good practice was shared with staff through a newsletter, safety briefs and incident review meetings. Information was shared across the health board, and not specific to the birth centre, meaning that staff had the opportunity to learn from different settings.

Whilst all staff who completed a questionnaire either agreed or strongly agreed that their organisation encouraged them to report errors, near misses or incidents, only two agreed that the organisation treats staff involved in an error, near miss or incident fairly. Only three staff members said the organisation does not blame or punish people who are involved in errors or near misses, whilst three said that it did, and the remainder neither agreed nor disagreed. Of the written comments we received, we were concerned to find that three staff

members felt there was a punitive management culture in relation to incidents. Four staff members also reported a lack of support and feedback following incidents.

Some staff we spoke with told us that morale was low, and they did not always feel supported by senior managers following the reporting of concerns, or clinical incidents.

The birth centre did not have an appointed ward manager, and managerial responsibilities, such as rosters, audits, training, and equipment checks were carried out by individual midwives. Whilst we were able to see that this activity was being carried out, we did not see that there was any overall responsibility or accountability being held by one person. We found during the inspection, and some staff and managers reported, that it was unclear who held overall responsibility and who they needed to speak with if there were any queries.

We were also told that the same structure applies to the community team, meaning there was no one person who was accountable, or responsible for the overall team.

Improvement needed

The health board must:

- Ensure that the maternity dashboard is able to monitor data appropriately against standards to ensure and take action where appropriate
- Explore the reasons why staff feel unsupported during/following a clinical incident or concern and take actions where necessary to address the issues
- Consider whether the managerial arrangements within the birth centre and community teams provided appropriate managerial support and oversight.

Staff and resources

Workforce

The birth centre had a number of core staff, including midwives and healthcare support workers, who were based solely in the birth centre. They were supported by the community midwifery team, who would be called into the birth centre to support at times when acuity levels increased. We spoke with a number of core

staff and community staff during the inspection, we also received 11 completed HIW questionnaires from a number of staff across the service.

As highlighted earlier, some staff we spoke with raised concerns about staffing levels within the unit, and more specifically within the community team. Issues raised by staff included long term sickness and vacancies within the community team, resulting in staff working long hours to ensure shifts were covered. It was evident to see that community staff and birth centre staff were working closely together, and supporting each other to ensure sufficient cover was provided. However, staff explained that the community on-call arrangements meant that they could often be working long hours when they were called in to provide support.

We were made aware that community staff could also be called to work in the obstetric unit, when the acuity levels became high. Staff told us that they did not feel happy, or always comfortable in this environment as their skills, knowledge and experience were based around low risk patients, the birth centre and home births. Staff we spoke with, and those who completed HIW questionnaires told us they believed this had an impact on their ability to carry out their community roles safely and provide continuity of care for women. Staff also reported that this had resulted in low morale.

We discussed this with senior managers who were aware of some of the issues, but not to the extent that staff had raised their concerns with the inspection team. When speaking with staff and managers, it became apparent that some staff were not raising staffing issues through appropriate channels, which would formally highlight to managers their concerns, and the impact of staffing on clinical activity and providing safe and effective care to patients.

Staff who completed a HIW questionnaire raised similar issues with regards to staffing levels. The majority of staff told us that there was only sometimes enough staff at the organisation for them to do their job properly. In addition to the staff we spoke to, five of the 11 staff who completed a questionnaire also raised concerns around staffing and the working environment, some of this feedback included the following:

> *“Staff shortages recently mean that often things are being missed potentially. Many clinics are without continuity and despite managers being aware there has been no offers of help”*

> *“I could not recommend my organisation as good place to work. My work place is currently understaffed and is a very*

stressful environment to work in. This is resulting in high sickness levels and very low staff morale"

Senior managers told us that there were plans in place to address all of the concerns. We were told that staff called in to support the obstetric unit would be offered to be placed into an environment they felt more comfortable in, such as antenatal or postnatal care. We were told that the maternity service had recently appointed a number of midwives into the obstetric unit to address the staffing issues, with the aim of reducing the need to call in community staff.

The directorate had recently started an exercise to collate information in relation to reviewing staffing across the service, in line with birth rate plus[8]. This included staffing rotas, financial information in relation to overtime and on-call arrangements. A report is due to be produced in December 2019, and we were told that action would be taken should there be a need to increase staffing numbers. Senior management told us that due to the recent reconfiguration of the service, they plan on conducting the review again in one years' time, to ensure staffing levels remain appropriate.

We were told there were plans to review maternity services across the health board, including the birth centre, with a view to looking at different ways of working, potentially new organisational structures and providing additional support to staff. Based on some of the concerns raised by staff, we suggested that the health board should consider communicating the plans and proposals to staff as soon as possible, in order for them to be fully sighted of the changes that may address some concerns.

We were told that staff should receive a personal appraisal and development review annually. We saw that this was monitored, and the birth centre completion rate was just under 60%. We were advised that work was being carried out to ensure all staff receive their appraisals in a timely manner. All staff who completed a HIW questionnaire confirmed they had an appraisal within the last 12 months.

We found there was sufficient number of supervisors to provide clinical supervision for midwives. Group supervision sessions were held regularly, and

[8] https://www.birthrateplus.co.uk/

areas for discussion could be adapted to incorporate learning from incidents or concerns.

Midwives were required to attend three mandatory study days annually to ensure their skills and knowledge were updated, these included PROMPT[9], statutory and professional skills. We were told that they were in the process of developing a community PROMPT day, to tailor the study day to the needs of the community and birth centre team. We were able to see that records of attendance were maintained by the practice development midwife, and there was a robust process in place to ensure that all staff attend the three days over the course of a year. We saw that staff had been booked onto courses for the remainder of the year to ensure they attended.

We were told that records to show whether staff had attended training on the Growth Assessment Protocol[10] were limited due to the way it was collated. Training was carried out on-line, and staff were able to use personal email addresses, meaning the health board was unable to monitor who had, or had not completed the training, and were reliant on staff providing certificates of completion.

Improvement needed

The health board must:

- Ensure that staff are aware of the reporting system to ensure there is sufficient oversight of staffing issues and the impact on delivering safe clinical care
- Ensure it considers the impact of staffing levels within the community when deploying midwives to work in the hospital

[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

[10] GAP/GROWTH Assessment Protocol (GAP) has been shown to significantly increase the detection of Fetal growth restriction (FGR) which is a significant cause of stillbirth, neonatal death and perinatal morbidity.

- Consider how it communicates with staff to ensure they are fully sighted of changes to the service
- Ensure it has a robust process to monitor staff compliance with GAP/Grow training.

4. What next?

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

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

The improvement plans should:

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

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

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

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

5. How we inspect hospitals

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

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Hospital: Neath Port Talbot

Ward/department: The birth centre

Date of inspection: 22 and 23 October 2019

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

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate assurance issues were identified on this inspection.				

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):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Neath Port Talbot

Ward/department: The birth centre

Date of inspection: 22 and 23 October 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must provide information to patients about the Community Health Council.	6.3 Listening and Learning from feedback	Notice Boards to be in place with clear advice and information on how to contact the Community Health Council. Information regards the Community Health Council is provided in the “Putting things right” leaflet. These leaflets are maintained in the clinical area	Matron – birth centre and Community Services Lead Midwife birth centre	January2020 completed
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must: • Consider whether the use of curtains in the rooms to hide equipment are upholding infection control standards • Provide HIW with assurance with regards to the process for testing water used for the birth pool. A policy and/or procedure must be made easily accessible to staff and clearly communicated.	2.4 Infection Prevention and Control (IPC) and Decontamination	Infection prevention Control Nurse lead invited to birth centre to complete risk assessment If curtains to be removed alternative solution to hide medical gasses to be sourced Estates to be contacted to provide assurance of water testing schedule Information to be cascaded to all relevant staff	Matron birth centre/Community	January 2020 January 2020 January 2020
The health board must ensure that:	3.1 Safe and Clinically Effective care			January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
• A pain assessment tool is used by staff to effectively monitor pain levels. • Regular evacuation drills are carried out to keep staff up to date with their skills.		Ask Consultant Midwives Cymru for standardised approach to pain assessment in Labour in a midwifery led intrapartum setting Plan a drill schedule for 2020 ensure all staff have the opportunity to partake in a drill.	Consultant Midwife Swansea Bay UHB Matron birth centre/community	January 2020
The health board must ensure that patient records clearly demonstrate the reason for a patient transfer out of the birth centre, and include an SBAR.	3.5 Record keeping	Ensure consistent and accurate use of all Wales Transfer form for every woman transferred from midwifery led intrapartum care to Obstetric Unit Upskill midwives in completion of appropriate SBAR form	Matron birth centre/Consultant Midwife	January 2020
Quality of management and leadership				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must: • Ensure that the maternity dashboard is able to monitor data appropriately against standards to ensure and take action where appropriate	Governance, Leadership and Accountability	Dashboard in development to be available to all staff in a central drive.	Data manager	January 2020
		Community midwifery statistics to be circulated monthly to community midwifery teams to understand personal performance toward development and support as required	Consultant midwife	January 2020
• Explore the reasons why staff feel unsupported during/following a clinical incident or concern and take actions where necessary to address the issues		One to One appointments with staff completed with available staff. Staff returning from leave to be offered appointment on return.	Head of Midwifery	January 2020
		New serious incident toolkit embedded into practice including learning events and staff support.	Head of Midwifery	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Clinical Supervisors to continue to support staff and report themes and trends to management team. Introduction of CWTCH service for staff to attend for support and advice	Head of Midwifery/CSfM's	Completed
		Staff side representatives available to all staff. Staff side representatives supported to maintain skills and attend updates	Head of Midwifery/Staff side representative	Completed
		Guardian service available to all staff Contact details available on intranet. Promote use of NHS staff survey	Matron birth centre	Completed
• Consider whether the managerial arrangements within the birth centre and community teams provided		Vacancy for overall lead midwife for birth centre/Community team currently in vacancy process	Head of Midwifery	January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
appropriate managerial support and oversight.				
The health board must: • Ensure that staff are aware of the reporting system to ensure there is sufficient oversight of staffing issues and the impact on delivering safe clinical care	7.1 Workforce	Safety brief completed and circulated to all staff to remind of the process for incident reporting staffing shortages	Head of Midwifery	Completed
• Ensure it considers the impact of staffing levels within the community when deploying midwives to work in the hospital		Review of Staff in post completed. Rotation of staff completed to cover sick leave and maternity leave. birth centre and Team at full establishment	Head of Midwifery	Completed
		Maintain and monitor database of all requests for support in Obstetric Unit. Community Midwives to work in area where they are confident to support where there is a need to attend	Matron birth centre/Community	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
• Consider how it communicates with staff to ensure they are fully sighted of changes to the service		Permanent Midwifery Matron in post. All midwives invited to professional Midwifery Forum- Monthly Team meetings to be held by Lead Midwife and Matron- Monthly schedule to be completed Maternity Unit meetings to be offered at least bi-annually. Schedule to be circulated	Head of Midwifery Matron birth centre/community Head of Midwifery	Completed January 2020 January 2020
• Ensure it has a robust process to monitor staff compliance with GAP/Grow training.		Database prepared for GAP/GROW training compliance All staff asked to register on the site using NHS email	Head of Midwifery	Completed

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Susan Jose

Job role: Interim Head of Midwifery

Date: 30/12/2019