Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Wrexham Maelor Hospital – Maternity Services, Betsi Cadwaladr University Health Board

Inspection date: 7 - 9 January 2020

Publication date: 14 April 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 978-1-80038-441-5

Contents

1. What we did 5

2. Summary of our inspection 6

3. What we found 7

Quality of patient experience 8

Delivery of safe and effective care 15

Quality of management and leadership 22

4. What next? 29

5. How we inspect hospitals 30

Appendix A – Summary of concerns resolved during the inspection 31

Appendix B – Immediate Improvement plan 32

Appendix C – Improvement plan 34

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 Wrexham Maelor Hospital within Betsi Cadwaladr University Health Board on 7, 8 and 9 January 2020. This inspection is part of HIW's national review of maternity services across Wales[1].

The following hospital wards were visited during this inspection:

- Simpson ward - antenatal ward (before delivery) with a capacity of 14 beds
- Lawson Tait - postnatal ward (following delivery) with a capacity of 18 beds
- Midwifery led unit - with a capacity of two delivery rooms and one birthing pool
- Labour ward - (during labour) with a capacity of eight delivery rooms and one birthing pool
- Triage assessment area and a waiting room
- One operating theatre and one recovery room.

Our team, for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one consultant obstetrician and two midwives). The inspection was led by a HIW inspection manager.

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

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

[1] https://hiw.org.uk/national-review-maternity-services

2. Summary of our inspection

Whilst we identified some areas for improvement, overall we found evidence that the service provided respectful, dignified, safe and effective care to patients.

There were some good arrangements in place to support the delivery of safe and effective care and positive multidisciplinary team working.

This is what we found the service did well:

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

This is what we recommend the service could improve:

- On call access to anaesthetist out of core hours
- Review of medical job plans
- Review of policies and procedures
- Pool evacuation training
- Signage and directions to the unit.

3. What we found

Background of the service

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

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

Wrexham Maelor Hospital is the district general hospital for the east area of North Wales, situated in the centre of Wrexham. The hospital serves a population of approximately 195,000 people. The acute hospital service has a total of 610 beds, with a full range of specialties.

Maternity services are managed as a North Wales networked service supported by a neonatal network. Services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provides care to women who chose to birth in the health board facilities who reside outside the geographical boundary.

The health board averages around 6,602 births per year, with around 2,577 of these at Wrexham Maelor Hospital.

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

Quality of patient experience

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

Patients were positive about their overall experience of the service. Most patients told us they were happy with the care and support provided to them. Without exception, patients told us they had always been treated with dignity and respect.

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

We found signage and directions to the unit needing review.

Health promotion was clearly displayed throughout the unit, however, smoking cessation information required improving.

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

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

> *"The staff on the labour ward and Simpson ward are beyond reproach in my opinion – I have no faults what so ever with the maternity unit."*
>
> *"The staff have been excellent could not have asked for better care for myself and my baby boy".*
>
> *"Been a very positive experience. Thank you to all the staff".*

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

Staying healthy

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

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

Improvement needed

The health board must ensure that smoking cessation information is readily available throughout the unit.

Dignified care

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

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

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

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

All of the staff we spoke with said they had received bereavement training and would feel confident in accessing the correct policies and support, to enable them to appropriately care for any recently bereaved parents. There was a dedicated bereavement room within the unit, known as the 'Butterfly Suite'. We saw this provided a comfortable environment for patients and families to use. If this room

was in use, we were told that an unoccupied postnatal room would be made suitably available. We were told that a bereavement lead who worked across the three sites within the health board was available through core working hours to offer support and advice. Staff also told us that the on-call matron for the maternity service would be the first point of contact if guidance was required outside of core hours.

All of the staff we spoke to confirmed the perinatal mental health support to be excellent, with all sharing knowledge of where to refer or escalate patients to when required.

Patient information

We found that directions to the maternity unit were confusing which would make it difficult to locate the specific wards within the unit. Visiting times were clearly displayed within the unit and staff told us there would be flexibility around this if requested.

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

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

Improvement needed

The health board must ensure that directions are reviewed to enable easy access to the unit from all entrances.

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

Communicating effectively

Overall, patients seemed to be positive about their interactions with staff during their time in the unit. All of the patients we spoke to said they felt confident to ask for help or advice when required and all also said they had been listened to by midwifery and medical staff during their stay. Patients we spoke to and who completed the questionnaires said that they had all been spoken to regarding their birth choices. This was also clearly documented in the case notes we reviewed.

We saw that staff maintained patient privacy when communicating information. We noticed that it was usual practice for staff to close doors of consultation rooms when providing care to protect patients' privacy and dignity.

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

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

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

We were also told by staff that active learning was seen through vibrant maternity voices[4] and birth afterthoughts groups [5], which are chaired by a service users. They had been created for mums-to-be and new mums to meet and discuss services, care and improvements. There was also a Facebook page seen for anyone wishing to learn more regarding maternity services within North Wales.

Timely care

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

We saw that patient observations were recorded on a recognised national chart to identify patients who may becoming unwell or developing sepsis. Staff were aware of the screening tool and reporting system for sepsis, which enabled appropriate and timely action to be taken.

Individual care

Planning care to promote independence

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

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

---

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

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

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

We were told by staff and patients that local parent craft groups such as breastfeeding and health promotion before and after delivery, were very beneficial for new mothers and fathers. Parent classes were also offered and delivered to families within the community clinics across the North East of Wales.

People's rights

We found that family/carers were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. These arrangements were recorded in patients' notes to ensure that all members of the team were informed of patient preferences.

Both staff and patients told us that open visiting was available, allowing the partner, or a designated other, to visit between 9.00am and 9.00pm. Staff also told us that birthing partners could stay with the patient during labour.

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

Listening and learning from feedback

Information was available on the health board's website relating to the process for patients to follow should they have concerns they wish to raise, there was also information available on the unit. We were told by the senior management team that ward managers within the unit were fully aware of the NHS Wales Putting Things Right[6] process and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints. We were also told by staff that if required, they would provide patients with details of the Community Health Council (CHC)[7] who could provide advocacy and support to raise a concern about their care. We also saw posters throughout the unit to promote this service.

---

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

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

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

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

Delivery of safe and effective care

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

Overall, there were good processes in place within the unit to support the delivery of safe and effective care.

We found there were robust processes in place for the management of medicines, pain assessment and clinical incidents, ensuring that information and learning is shared across the service.

We identified areas for improvement regarding birthing pool training within the unit.

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

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

Safe care

Managing risk and promoting health and safety

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

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

We looked at the arrangements within the unit for accessing assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells. We found the emergency trolley, for use in a patient emergency, was well organised and contained all of the appropriate

equipment, including a defibrillator. The emergency drugs were also stored on the resuscitation emergency trolley and we were assured that regular stock, date and maintenance checks were taking place on this equipment.

Emergency evacuation equipment was seen within the birth pool rooms, which could be used in the event of complications during a water birth. However, although we were told by staff and senior managers that all staff caring for patients within the birthing pools had received the appropriate training required, we could not be assured that this was the case as we were unable to see the evidence to verify this.

Improvement needed

The health board must ensure that all staff caring for patients within the birthing pools are appropriately trained and this is documented accordingly.

Falls prevention

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

Infection prevention and control

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

During the inspection, we observed all staff adhering to the standards of being Bare Below the Elbow[8] and saw good hand hygiene techniques. We found hand washing and drying facilities were available. We also saw information displayed to promote the correct hand washing procedure for staff to follow. Hand sanitiser

[8] Best practice is for staff involved in direct patient care to be bare below the elbow, this includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), wrist watches, nail polish or false nails.

gel dispensers were also seen easily accessible throughout the unit to promote infection prevention control.

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

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

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

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

Nutrition and hydration

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

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

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

Medicines management

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

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

We looked at a sample of medication records and saw these had been completed appropriately. Pharmacy support was available to the unit. An out-of-hours computerised process was available for staff to check stock and availability of drugs across the hospital during these times, to ensure there were no delays in patients receiving medication. The unit also had access to a stock of take home medication, allowing patients to be discharged in a timely manner.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be at risk. Safeguarding training was mandatory and all staff we spoke to confirmed they had received training within the past 12 months.

There was an appointed lead safeguarding midwife for the health board who would provide support and training to staff. We were told that safeguarding training included guidance regarding female genital mutilation, domestic abuse, sexual exploitation and bruises on babies, as well as the procedures to follow in the event of a safeguarding concern.

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

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

Medical devices, equipment and diagnostic systems

We considered the arrangements for the checking of the resuscitation equipment within the unit. We found the checks on the adult resuscitation equipment to be consistently recorded, however, we found gaps in the daily checking and

recording of the neo-natal resuscitaire[9]. Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

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

Effective care

Safe and clinically effective care

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

The inspection team saw that the midwifery led unit had admission criteria that facilitated birth for low risk women with group B strep[10] or who required induction of labour for a postdates pregnancy, thus encouraging normality. This was seen to be good practice as it promoted birth choice continuation.

We were also told that the unit had dedicated theatre staff coverage from the general theatres in the hospital, for caesarean sections or other surgical procedures. Two obstetric operating theatres were seen and were well organised, stocked and had satisfactory space. One of the two obstetric theatres was smaller than the other, and mainly used as a recovery area for the other, larger theatre. This second theatre could however be used in an emergency requiring an open theatre and was sufficiently large enough to allow for this. Midwives we spoke with confirmed that unless they were trained to do so, they

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

[10] Group B streptococcal meningitis (GBS) disease (meningitis, septicaemia and pneumonia) is the main cause of meningitis in babies.

were never expected to practice as a scrub nurse[11] and perform scrub duties. They also told us that maternity and theatre staff worked well together as a team.

We were told that middle grade anaesthetic doctor cover was dedicated to maternity services until 9.30pm. After 9.30pm, we found that the anaesthetic middle grade covering surgical emergencies went home. This left a consultant anaesthetist covering obstetrics and surgical emergencies from home (a separate consultant and middle grade covering Intensive Therapy Unit). The middle grade anaesthetic doctor for obstetrics may have to cover serious surgical emergencies until the consultant arrived from home. This could lead to a delay in an emergency caesarean section if the middle grade doctor is otherwise occupied. This was felt to be a risk which requires further review.

We saw that a breastfeeding coordinator was appointed and support was available to all who required this, however midwives and maternity support workers also told us that if the breastfeeding coordinator was unavailable due to workload, they were also able to support where required.

Improvement needed

The health board must ensure that anaesthetic cover is reviewed to maintain continuity of care.

Quality improvement, research and innovation

A lead clinical research and improvement midwife was in place, who covered maternity services across the health board. We were told that projects to support education in growth assessment protocol (GAP) and gestational related optimal weight (GROW)[12], epilepsy in patients, and a full review of documentation and the creation of care pathways across the unit had been recently completed. We

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

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

were told that further work was planned to implement the use of innovation champion midwives across the service, who would be encouraged to become involved in innovation and research projects to support the team.

The health board maternity practice development midwife was also seen to carry out the inspirational work of Practical Obstetric and Multi-Professional Training (PROMPT)[13].

We were also informed of the introduction of Cardiotocography (CTG)[14] champions of which the inspection team found to be noteworthy practice. Training would be attended by the champions in the near future to enable them to share and promote evidence based practice throughout the unit.

Information governance and communications technology

During the inspection, we found improvements were required in records storage areas situated between the postnatal and antenatal wards. This was immediately escalated to the senior matron and a keypad lock was immediately fitted to the storage areas to prevent unauthorised access. More details of this are included in Appendix A of this report. Throughout the rest of the unit, we found secure measures in place to store patient information to uphold patient confidentiality and to prevent unauthorised access.

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

We found that a monthly maternity dashboard was produced which included information in relation to each hospital and across the health board. This provided information with regards to the clinical activity, induction of labour, clinical indicators and incidents. The dashboard was rated red, amber and green depending upon the level of associated risk.

---

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

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

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

Improvement needed

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

Record keeping

Overall, we found a good standard of record keeping in care plans between multidisciplinary teams. We saw appropriate observations charts, risk assessments, care pathways and bundles being used.

Quality of management and leadership

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

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

Specialist midwives were appointed across the health board and we found them to be useful and knowledgeable resources for the unit teams.

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

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

We recommended improvements in medical job planning and succession planning in some midwifery roles to maintain continuity of care.

Governance, leadership and accountability

We saw a number of regular meetings were held to improve services and strengthen governance arrangements. Such meetings included a monthly maternity quality and safety group, monthly audit review meetings and obstetric clinical review of incident meetings. Additionally, there were monthly ultrasound screening, labour ward, postnatal and neonatal forums and weekly multidisciplinary meetings such as CTG reviews. We found there was good overall monitoring and governance of the staffing levels of the service.

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

The senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)[15] and Each Baby Counts[16] were taken forward in the unit. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies such as MBRRACE and ongoing work takes place to ensure the unit is in line with the recommendations made.

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

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in place, who held responsibility for reviewing, investigating and managing clinical incidents across the health board. All staff we spoke with told us that the organisation encourages them to report errors, near misses or incidents and that these were never dealt with in a punitive manner.

Monthly risk meetings are held at Wrexham Maelor Hospital where reported incidents, investigations and their findings were discussed in a multidisciplinary format. We saw that minutes were produced and information/learning shared across maternity services across the health board to support changes to practice and learning. We were assured that the internal risk register was monitored and acted upon when required.

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead governance midwife presented themes and trends

[15] MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK with the aim of providing robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.

[16] Each Baby Counts - the Royal College of Obstetricians and Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

to this meeting, with the view of highlighting any areas of practice improvements required across the heath board. Lessons learnt are shared and circulated to all staff within a monthly feedback newsletter, summarising the month's issues which staff told us was very useful.

Staff felt the daily leadership within the unit to be excellent and said the senior team members would hold monthly visits to all sites which gave staff the opportunity to gain feedback and support if required.

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

Staff and resources

Workforce

All staff we spoke with felt they received excellent leadership and support, personally and professionally. Strong team working was seen to be encouraged by all senior managers. This was confirmed by staff we spoke with and those who completed the 29 questionnaires we distributed. A number of staff said they considered their working environment to be positive and they were happy to work within Wrexham Maelor Hospital. Some of the comments from staff included the following:

> *"As part of a small core team of midwives I feel completely supported, motivated and able to suggest improvements / changes to my immediate current manager, who is open honest and approachable and recognises career development in myself".*

> *"Having worked previously in other trusts I would not leave Wrexham Maelor, cannot recommend the services enough. The outstanding*

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

teamwork, support and prioritising of patient care and safety makes Wrexham a hospital I am proud to work for".

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

We were told by all staff that midwifery and healthcare support worker's rotas were managed well within the unit. If there were any shortages of midwifery cover, the daily (out of core hours) midwife on-call system would be activated. However, from the staff questionnaires we received it was noted that core healthcare support workers were no longer allocated to the labour ward. Staff felt this had a detrimental effect on the care that could be given and also reduce the learning and skills competencies for the members of staff.

We saw there were departmental escalation processes in place and all staff we spoke with were aware of where to locate the policy and how to escalate issues such as staffing shortages. Senior staff also told us that if required, clinically trained office staff would cover shortages where required.

Medical staff we spoke with felt that although there are gaps in middle grade staffing across the unit, medical rotas were being managed well to cover this. However, some medical staff we spoke to advised that the process of completing job planning was administrative rather than meaningful and did not involve the setting of personal and service objectives. This was seen to have a detrimental effect on quality improvement of services. We spoke to the senior medical team and they acknowledged that this was an area for improvement and advised that work plans would be reviewed imminently. The clinical director of the unit confirmed that the job planning of consultant obstetrician and gynaecologists is

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

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

under review and this involved an external consultancy agency to help make the required improvements.

We saw evidence of robust induction programmes for both midwifery and medical staff and staff felt these were of benefit when commencing their role. We also saw that the training and mentorship arrangements for medical staff was very positive. Medical staff we spoke with confirmed that the training, support, guidance and supervision is of a high standard. Medical and midwifery staff also said the organisation encourages and supports good teamwork. We also saw evidence of good relations and respect for each other's contribution to patient care from diverse members of the multidisciplinary team.

We found there was a process in place for monitoring staff attendance and compliance with mandatory training. Health board mandatory training, such as health and safety, fire safety, infection prevention and control and safeguarding, is predominately completed on-line and is monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire to ensure they remain within timescales.

The service holds three mandatory maternity related study days across the year. One of the days is practical obstetric multi-professional training (PROMPT) training, which is a multidisciplinary training event used to encourage multidisciplinary working in emergency situations. All staff we spoke with said they attend this training when they can and find it very useful. We were shown compliance figures for PROMPT training and were assured that regular training was taking place. This was also confirmed in the staff questionnaires received. We were also assured that all staff had received appropriate CTG training.

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

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

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

that continuous professional development and training time is given to all staff within their working hours.

Speaking to some of the senior medical staff, it was noted that there is an aptitude for some to go beyond their current leadership roles with the right development and coaching to reach their full potential.

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

Upon speaking with staff, the inspection team were concerned that there did not appear to be any succession planning in the roles for the PROMPT facilitator nor the infant feeding coordinator.

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

Improvement needed

The health board must ensure that:

- Core healthcare support worker allocation is reviewed to maintain safe practice and competence based learning
- Medical work plans are reviewed to ensure adequate medical cover is in place at all times
- Further senior leadership, development and coaching is available for progression in current roles
- Succession planning is reviewed for the roles with limited resource and staff coverage such as PROMPT Trainer.

4. What next?

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

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

The improvement plans should:

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

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

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

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

5. How we inspect hospitals

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

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

Service: Wrexham Maelor Hospital

Area: Maternity Services

Date of Inspection: 7 – 9 January 2020

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Patient records within a link storage room upon the postnatal and antenatal wards were insecurely stored.	Confidential patient records could be accessed by unauthorised individuals.	We spoke with staff immediately to highlight the concerns.	A lock was immediately fitted to the accessible door and staff were advised of the importance of safe storage of patient information.

Appendix B – Immediate Improvement plan

Service: Wrexham Maelor Hospital

Area: Simpson Ward, Lawson Tait Ward, Labour Ward and Midwifery Led Unit

Date of Inspection: 7 – 9 January 2020

Delivery of safe and effective care				
Improvement needed	**Regulation / Standard**	**Service action**	**Responsible officer**	**Timescale**
<u>Finding</u> The inspection team considered the arrangements for the checking of emergency equipment throughout the unit. We found that checks of equipment used in a patient emergency were insufficient. This is because checks were inconsistent and not recorded as being carried out on a daily basis. We found this in relation to neo-natal resuscitation equipment within the postnatal ward of Lawson Tait.	2.1 Managing Risk and Promoting Health and Safety 2.9 Medical Devices, Equipment and Diagnostic Systems	Following the unannounced inspection, staff have been reminded that daily checks of neonatal resuscitaires will be the minimum expected standard. This has been communicated to all staff via safety briefings and will be communicated at every opportunity for a minimum period of two weeks. The Ward Manager has commenced monitoring compliance on a daily basis and the Matron, as an extra	Ward Manger Ward Manager Matron	Complete Complete

<u>Improvement needed</u> **The health board must provide HIW with details of the action it will take to ensure that checks of the neo-natal resuscitaires are carried out and recorded on a daily basis and in line with their policy.**		measure, will also monitor compliance during a daily walk about on the unit. Any concerns identified will be addressed immediately with the staff member responsible for completing the neo-natal resuscitation equipment checks and an action log will be completed. The Matron will continue to audit compliance of daily checks by completing a weekly audit, and will take every opportunity to remind staff of the lessons learned following the unannounced inspection. The learning from this unannounced inspection has been communicated to all staff within the Directorate and will continue to be communicated at all interdepartmental meetings.	Matron Senior Leadership Team	Complete Complete

Health Board Representative:

Name (print): **Fiona G Giraud**

Role: **Director of Midwifery and Women's Services** **Date:** **14-1-2020**

Appendix C – Improvement plan

Service: Wrexham Maelor Hospital

Area: Maternity Services

Date of Inspection: 7 – 9 January 2020

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that smoking cessation health promotion is readily available throughout the unit.	3.2 Communicating Effectively	The Women's Directorate has worked in partnership with Public Health to secure the relevant information for display in the clinical areas for women and their families. Smoking cessation information is now displayed in all clinical areas. The importance of Health Promotion for women has been highlighted to all staff within the maternity unit.	Inpatient Matron	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The local Public Health Team has agreed to review all available patient information on a six monthly basis and will forward any new posters/information to the Matron for display in all ward areas. The Ward Manager will review the information displayed on a monthly basis and will display all new information on a six monthly basis as forwarded by the Public Health Team. This will be monitored at the site monthly accountability meetings, as part of the Women's Directorate Assurance Framework.	Public Health Inpatient Matron Ward Manager	Complete and ongoing Complete and ongoing
The health board must ensure that directions are reviewed to enable easy access to the unit from all entrances.	3.2 Communicating Effectively	The Women's Directorate has liaised with the Director of Estates and Facilities and has been advised that the Wrexham Hospital Management Team is currently reviewing signage on the Wrexham Maelor Site which will include Maternity Services. Costed options are being	Hospital Management Team	Commenced and ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
		prepared for submission for capital funding and / or from charitable funds in 2020/21.		
Delivery of safe and effective care				
The health board must ensure that all staff caring for patients within the birthing pools are appropriately trained and this is documented accordingly.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care	Lead midwives have been identified to deliver pool evacuation training. The Leads have had training from the Manual Handling Department to ensure the safety of staff during this skills drill. All core staff have been trained and the remaining staff will have completed their training by the end of March 2020. A register of all staff trained is completed by the Lead Midwives. The compliance with pool evacuation training has been added to the Directorate's Mandatory	Lead Midwives Lead Midwives Lead Midwives	Complete Commenced and for completion by 31 March 2020 Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Training database for North Wales for monitoring and auditing purposes.		
The health board must ensure that anaesthetic cover is reviewed to maintain continuity of care.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care	At present there are three on-call tiers from 08:30 until 21:30 daily. After 21:30 there are two tiers to cover Obstetrics and ICU, with the consultant on-call covering theatres from home. Withdrawal of the third tier overnight was a Deanery directive following a visit in 2012. There were further discussions with the Deanery about this level of cover in 2013/14. Work is ongoing in anaesthetics to increase the service to three tiers to support continuity of care.	Clinical Lead for Anaesthetics	Ongoing
The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	3.1 Safe and Clinically Effective Care	The Women's Written Control Document Group has an action plan that lists all policies and guidelines developed, which includes revision dates. All policy/guideline authors are approached by the appropriate Forums	Written Control Document Group Forum Chair	Complete Complete

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
		triumvirate leadership teams, to enforce and support lines of accountability.		March 2020
		Written Control Document expiry dates have been extended to March 2020 to ensure staff are fully aware that the Written Controlled Documents on the intranet remain live for their support.	Written Control Document Group	
		The Health Board have developed a formal route for written control documents to ensure that any policies approaching their expiry date, are reviewed and updated in a timely and appropriate manner.	Written Control Document Group	Commenced and ongoing
		The Director of Midwifery and Women's Services and North Wales Clinical Lead are monitoring the progress made at monthly Senior Management Team meetings.	The Director of Midwifery and Women's Services North Wales Clinical Lead	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Monthly meetings have been arranged for the Chairs of the Women's Directorate Forums, the Governance Lead and the Director of Midwifery to monitor progress and performance against the Written Controlled Document action plan. The health board requires that all policies developed are ratified by the Corporate Quality & Safety Group. The Women's Directorate are compliant with this request and all new WCD are on the agenda for Corporate Quality & Safety Group meetings.	The Director of Midwifery and Women's Services The Director of Midwifery and Women's Services	Complete and on-going Complete and ongoing
Quality of management and leadership				
The health board must ensure that core healthcare support worker allocation is reviewed to maintain safe practice and competence based learning.	3.1 Safe and Clinically Effective Care 7.1 Workforce	As part of each new starter's induction programme, staff including healthcare support workers are allocated to work in all clinical areas, ensuring skills are developed to meet the requirement of the role. This will ensure all staff access competence based learning and will maintain safe practice.	Inpatient Matron	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		At each Personal Annual Development Review (PADR), training needs are discussed and where development areas are highlighted, the line manager will work with the healthcare support worker to ensure any additional competency based learning is accessed.	Ward Managers	Complete and revisited annually
The health board must ensure that medical work plans are reviewed to ensure adequate medical cover is in place at all times.	3.1 Safe and Clinically Effective Care 7.1 Workforce	An external Consultancy Team is working with the Women's Directorate to review individual job plans and to support a team job planning exercise. The final report and recommendations will be presented to the health board in April 2020.	External Consultancy Team Clinical Lead North Wales	Commenced/ To be Completed in April 2020
The health board must ensure that further senior leadership, development and coaching is available for progression in current roles.	3.1 Safe and Clinically Effective Care 7.1 Workforce	The Directorate offers professional development for all staff. Staff are encouraged to liaise with their line managers to identify areas in which	Senior Leadership Team All Line Managers	Complete and ongoing Complete and ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
		they feel they need to professionally develop during their annual appraisal.		
		Shadowing opportunities are available to staff at all levels of leadership within the Directorate and nationally.	All Line Managers	Complete and ongoing
		Secondment opportunities within the health board, local authorities and nationally, are also encouraged and supported by the Directorate.	Senior Leadership Team	Complete and ongoing
		Staff are actively encouraged to join policy development groups and to support audit by linking with the relevant audit leads.	Site Leadership Team	Complete and ongoing
		Clinical midwives are also given some designated responsibility for linking with other services i.e. bereavement and maternity voices.	All Line Managers Matrons	Complete and ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Coaching is available to midwives via the Clinical Supervisors for Midwives, who have been trained to coach staff. Coaching has been arranged for members of the North Wales Senior Leadership Team, who have highlighted this as an area for further development. The Coaching has been facilitated via an external agency working with the Directorate.	Clinical Supervisor for Midwives Deloitte	Complete and ongoing Complete
The health board must ensure that succession planning is reviewed for the roles with limited resource and staff coverage such as PROMPT Trainer.	3.1 Safe and Clinically Effective Care 7.1 Workforce	There are PROMPT Faculties in each Maternity Unit and Community Area, who can lead and deliver the required PROMPT sessions within the health board in the absence of the PROMPT Lead. The Faculty approach ensures appropriate leads are available for all PROMPT sessions, and supports robust succession planning.	PROMPT Faculties	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Succession planning is being considered for specific roles within the Governance Team and is part of a priority in the Directorate Workforce three year plan.	Governance Lead Senior Management Team	Commenced and ongoing

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

Service representative

Name (print): **Fiona Giraud**

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

Date: **2 March 2020**