Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Announced)

Community Hospital Free Standing Birth Units – Maternity Services, Powys Teaching Health Board

Inspection dates: 10 - 14 February 2020

Publication date: 21 July 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**

Fax: **0300 062 8387**
Website: **www.hiw.org.uk**

Digital ISBN 978-1-80038-912-0

Contents

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

Our purpose

To check that people in Wales are receiving good care.

Our values

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

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspections of the community hospital birth units within Powys Teaching Health Board on the 10 – 14 February 2020. These inspections are part of HIW's national review of maternity services across Wales[1].

The following hospital free standing birth units were visited during these inspections:

- Llandrindod Wells Memorial Hospital (Ithon Birth Centre), with a capacity of two birthing rooms including one birthing pool and one clinical room.
- Brecon Hospital (Brecon Birth Centre), with a capacity of one birthing room including one birthing pool and one clinical room.
- Welshpool Memorial Hospital (Welshpool Birth Centre), with a capacity of three birthing rooms.
- Newtown Hospital (Newtown Birth Centre), with a capacity of one birthing room including one birthing pool and one clinical room.
- Llanidloes War Memorial Hospital (Llanidloes Birth Centre), with a capacity of two birthing rooms including one birthing pool and one clinical room.
- Knighton Hospital (Knighton Birth Centre), with a capacity of one birthing room including one birthing pool and one clinical room.

Our team, for the inspection comprised of two HIW inspectors and two midwife clinical peer reviewers. The inspection was led by a HIW inspection manager.

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

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

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

2. Summary of our inspections

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 rated the care and treatment provided during their time in the units as excellent
- We observed professional and kind interactions between staff and patients, and care was provided in a dignified way
- There was a safe and robust process inspected for medicines management
- Documentation was of a high standard
- Excellent health promotion information was seen throughout the units
- Care given was to a high standard with clear continuity in care planning
- The units were all found to be clean, welcoming and suitable to meet the needs of mothers to be and their families.

This is what we recommend the service could improve:

- Evacuation methods of the birthing pool
- Review of emergency drill processes
- Review of environments within Llanidloes War Memorial Hospital and Knighton Hospital.

3. What we found

Background of the service

Powys is a rural health board that provides some services locally, through GPs, community hospitals and primary care community services. Powys provides services for some 133,000 residents over a large, rural geographical area.

Powys Teaching Health Board does not have its own District General Hospital, but pays for Powys residents to receive specialist hospital services in hospitals outside of the county. Shrewsbury and Telford Hospitals NHS Trust makes up the largest proportion of the commissioned activity and Wye Valley NHS Trust is the second largest. In Wales, the health board buys services from Hywel Dda, Aneurin Bevan, Swansea Bay and Cwm Taf Morgannwg University Health Boards. This covers all specialities, however Powys Teaching Health Board is not the majority commissioner of any acute provider.

Maternity 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 over 220 births per year, which has remained relatively stable over the last three years.

Women who birth within the health board area have the choice of two birth settings types. These include homebirths and free-standing midwife birthing units across the locality of Powys.

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. They told us they were happy with the care and support provided to them. Without exception, patients also told us that they had always been treated with dignity and respect.

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

Health promotion information was clearly displayed within the birthing units.

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

During the inspections, we distributed HIW questionnaires to service users to obtain their views on the standard of care provided. A total of 15 questionnaires were completed. We were also able to speak with 12 patients during the inspections.

Comments from patients who completed questionnaires included:

> *"The staff were so supportive and brilliant the whole time from the midwives to the maternity support worker they're all amazing and go above and beyond for our needs"*
>
> *"This unit and the staff are absolutely amazing and would recommend it to anyone".*

Staying healthy

Across the units, we saw adequate information displayed for patients on notice boards, and leaflets were readily available to inform patients of how they can stay safe and healthy. Information in relation to breastfeeding and skin to skin advice was displayed within the units, to inform patients about the benefits of both, to

help them make an informed decision about their care. Hand hygiene posters and hand washing guides were also displayed.

We saw information in relation to smoking cessation throughout the birth units. We were also told that the health board are currently developing roles of smoking cessation leads to provide support and information to patients. We also noted leaflets on healthy eating and the recommended vaccinations during pregnancy widely displayed. We found from a sample of maternity care records reviewed, that public health messages were clearly documented, for example, smoking cessation advice.

Dignified care

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

There were en-suite facilities within the birthing rooms on all of the units, which helped promote patients' comfort and dignity during their stay. All patients who completed questionnaires told us that the units were clean and tidy. Patient comments included:

> *"It's always lovely and clean and quiet here at the unit".*

We saw that staff maintained patient privacy when communicating information. We noticed that it was normal practice for staff to close doors of rooms to protect the patient's privacy and dignity when providing care and support.

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

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

Patient information

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

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

Information was available in both Welsh and English. Notice boards throughout the units highlighted areas such as Putting Things Right[2], Powys Birth Reflections and Trauma Service and Domestic Abuse services for Powys.

We saw within all units a 'Who's Who' staff information board which was useful in informing patients and families who they would be likely to see within the units.

We also noted that information was displayed within all units pertaining to dashboard data and statistics. We were told that this data was also regularly shared with the public on the open Facebook page, which the inspection team found to be good practice.

Communicating effectively

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

The use of language line was available for those patients whose first language was not English, meaning they were able to access care appropriate to their needs. From a sample of maternity care records reviewed we also found documented evidence to highlight that communication needs, including the need for interpreters or for the information to be made available in other languages were fully assessed during antenatal appointments.

---

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

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

Timely care

Although there were no labouring patients seen in the units at the time of the inspections, we were told by staff and patients who had been invited in to speak with us that, staff would always do their utmost to ensure patients were regularly checked for personal, nutritional and comfort needs.

All staff we spoke with in the birthing units told us that they were able to achieve high standards of care during their working day.

Individual care

Planning care to promote independence

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

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

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

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

People's rights

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

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

The birthing rooms within the units were equipped with a birthing ball, birthing mat and a bed to help meet the patients' birth choices. However, the option to have a water birth was not available to all patients as there was no birth pool in the Welshpool Birth Unit. This may have had a detrimental effect on the number of patients who booked to give birth there.

We were told that to help patients make informed choices, discussions about the birth options take place at the initial booking appointments and continued throughout the pregnancy. This was evident from the completed questionnaires with all respondents agreeing that staff had explained their birth options, any risks related to their pregnancy and that support they had been offered. These discussion were also found to be clearly documented in the sample of maternity care records we reviewed.

Listening and learning from feedback

We saw information leaflets and posters throughout the units relating to the complaints procedure for patients to follow should women or their families have concerns they wish to raise. Information was also available on raising concerns and advocacy support on the health board's website. We were told that staff were fully aware of the NHS process for managing concerns - Putting Things Right, and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints but that they did not routinely provide patients with details

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

of the Community Health Council (CHC)[4], who could provide advocacy and support to raise a concern about their care.

Improvement needed

The health board must ensure that:

- Birthing pool facilities are reviewed within the Welshpool Memorial Hospital to increase birthing numbers within the unit
- Patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

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

Delivery of safe and effective care

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

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

We found that 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 found patient safety was promoted in daily care planning and this was reinforced within the maternity care records we reviewed.

However, we identified areas for improvement in record keeping.

The service described clear and concise arrangements for safeguarding procedures, including the provision of staff training.

Safe care

Managing risk and promoting health and safety

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

We looked at the environment and found sufficient security measures in place to ensure that babies were safe and secure within the units. We noted that access to the birthing units was restricted by locked doors, which were only accessible with a staff identity pass or by a member of staff approving entrance.

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

The inspection team reviewed the pool evacuation process within the birthing units of Llandrindod Wells, Brecon, Newtown, Llanidloes and Knighton and found that upon speaking with staff that there were inconsistencies in the processes being followed. It was also noted by the inspection team that evacuation

equipment, such as slide sheets or evacuation nets were not currently in place in all units.

We also noted that there were inconsistencies in emergency alarm drill testing in all of the units for emergency situations, such as a baby/patient requiring resuscitation. When the inspection team tested the processes, variance were seen in the emergency team arriving to the birthing units, with issues, such as their inability to access the units due to not knowing the access keypad number and staff arriving to the units without the defibrillation trolley.

Details of the immediate improvements we identified are provided in Appendix B.

We also saw from the maternity care records we reviewed and were told by staff that there were incidents regularly raised regarding communications between the units and the Welsh Ambulance Service Trust (WAST). These relate to the grading of the call being made and advice being given by the call handlers regarding the appropriate escalation processes to be followed by midwives. The health board reported that this was having a detrimental effect on response times to the community units in emergency situations.

Falls Prevention

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

Infection prevention and control

We found that the clinical areas of the birthing units were clean and tidy and we saw that Personal Protective Equipment (PPE) was available in all areas apart from the birthing rooms within the Welshpool Birthing Unit. We were advised by staff that PPE is readily available in all birthing kit bags, however it was advised by the inspection team that accessible equipment should be placed within all clinical rooms for ease. Patients who completed a questionnaire thought the units were well organised, clean and tidy.

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

We were also assured that infection prevention and control training compliance was to a high standard, and any concerns that were raised regarding infection prevention and control would be escalated to senior members of staff. We saw results from an infection control audit which recently had been carried out by the health board. This audit showed that compliance with infection control was high and any work required was appropriately dealt with in a timely manner. Within all of the units, maternity statistics were also clearly displayed to show good practice, excellent compliance rates and achievements within the services as a whole.

We found equipment to be clean and ready for use in all units and we also noted that cleaning schedules for the units were in place and up-to-date.

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

The inspection team did however feel that upon review, the units within the Llanidloes War Memorial Hospital and Knighton Hospital required review to ensure that modernisation and improvements takes place.

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

Improvement needed

The health board must ensure that:

- Escalation and engagement with WAST is reviewed to ensure patient safety in the event of an emergency
- Access to PPE within the units is reviewed to ensure infection prevention and control measures are in line with health board policy
- A review of the facilities within Llanidloes War Memorial and Knighton Hospitals takes place to ensure that infection prevention and control measures are in line with health board policy.

Nutrition and hydration

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

Within all of the community hospitals, there were facilities available to purchase drinks if required. We were also told by staff that water jugs and tea and coffee facilities would be made available in the birthing rooms.

Medicines management

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

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

We also noted that a medicines management policy was in place and up-to-date and the staff that we spoke to acknowledged that they were aware of where to access the policy.

Safeguarding children and adults at risk

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

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

We were told that formal safeguarding supervision sessions are held regularly and staff are encouraged to discuss issues in a group supervision session. The lead safeguarding midwife was also available for telephone discussions to provide support and guidance to staff on the units.

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

Medical devices, equipment and diagnostic systems

We found the checks on the neo-natal resuscitaire[6] to be consistently recorded demonstrating that they had been carried out on a daily basis. We also found the neonatal resuscitaires within all units to be adequately and appropriately fully stocked.

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

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

Effective care

Safe and clinically effective care

The majority of staff who completed a questionnaire shared that they were always or usually happy with the quality of care they were able to give to their patients within the birthing units. We were told by staff that patients in the birthing units would always be kept comfortable and well cared for. We also saw good evidence of assessment and treatment plans throughout the maternity care records reviewed. Within this sample, we were also able to see that clinical need prioritisation was taking place and that it was forefront in care planning.

We were told that there is an infant feeding coordinator appointed within the health board, staff also said that they would feel happy to give support in all methods of feeding when required.

Quality improvement, research and innovation

A consultant midwife who is responsible for leading on clinical research and innovation was in post, and supported all maternity services across the health board. Midwives were also encouraged to get involved in research projects to support the team. The clinical research and innovation midwife was also involved in research associated with local university projects to support service and patient experience development.

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

Information governance and communications technology

We found secure measures in place to store patient information, upholding patient confidentiality and to prevent unauthorised access within the units.

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 and at the time of the inspections.

We found that a quarterly maternity dashboard was produced which included information in relation to each birth unit and across the health board. This provided information with regards to the clinical activity such as birth rates and infection prevention and control activity.

Record keeping

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

We considered a sample of maternity care records which demonstrated that appropriate risk assessments, including those for deep vein thrombosis, had been completed. However, in one maternity care record we saw inconsistency in the routine enquiry form being completed. Records showed that pain was being assessed and managed appropriately.

We did however see good accountability and signage within the nine maternity care records we reviewed.

Improvement needed

The health board must ensure that:

- Concise record keeping is maintained
- Policies and procedures are reviewed and updated within appropriate timescales to ensure consistency in care.

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 units.

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

Operational Team Leaders were appointed across the health board and we found them to be useful and knowledgeable resources for the unit teams.

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

Governance, leadership and accountability

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

We could see that there was an excellent level of oversight of clinical activities and patient outcomes. A monthly maternity dashboard was produced, which included information in relation to the whole health board, but also broken down to each unit. This provided information on the clinical activity on the units, such as category of births and also clinical indicators and incidents, such as complaints and investigations. The dashboard was rated red, amber and green depending upon the level of risk meaning that prioritisation and risk management could be managed appropriately.

In addition, the senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies:

Reducing Risk through Audits and Confidential Enquiries (MBRRACE)[7] and Each Baby Counts[8] were taken forward in the units. 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 units are in line with the recommendations made.

We saw evidence of audit completion, such as internal infection prevention audits for hand hygiene. We also saw recent evidence of health and safety and fire drill audit compliance.

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

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead risk and governance midwife also presented themes and trends to this meeting, with the view of highlighting any areas of practice, which needed to be addressed across the health board. Following this meeting, a monthly feedback newsletter was produced and circulated to all staff, summarising the month's issues. We also saw that this newsletter was used to provide positive feedback to staff, and to highlight where good practice had been evident. We saw that minutes were produced and information/learning shared within maternity services and across the health board to support changes to practice and learning. This information also included other maternity sites within

[7] 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, newborn and infant health services.

[8] 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.

the health board, with a view to sharing best practice and any learning in order to improve practice and processes.

Staff and resources

Workforce

During the inspections, we were able to speak with many members of staff within the units and we also received 52 completed staff questionnaires which we had distributed. Overall, the majority of staff told us that they felt fully supported by their senior managers and that peer support was also very good. Staff reported that there was good multidisciplinary working within the service. Some comments received in the completed HIW questionnaires were:

> *"Management very supportive and always has time to listen and help. Goes above and beyond to support individuals professionally and personally and the team as a whole. It is a privileged to have her as our team's band 7".*

> *"Our senior management team always encourage inclusion with meetings and decision making".*

The staff we spoke to also told us that the organisation encourages and supports team working.

The majority of staff who completed a questionnaire said they were involved in decisions about changes that affect their work, and half of staff said that communications were effective.

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

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

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

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

The service holds three mandatory maternity related study days across the year. One of the days is Practical Obstetric and Multi-Professional Training (PROMPT)[9], which is a multidisciplinary training event used to encourage effective multidisciplinary working in emergency situations. All staff we spoke with, told us they attend the training and find it very useful. We were shown compliance figures for PROMPT training and were assured that training was appropriately taking place within the correct timescales.

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

There is also a clinical supervisor for midwives in place across the health board. This role offers group supervision and one to one meetings which were also seen to be compliant with the clinical supervisor for midwives key performance indicators[10]. The health board monitor compliance with this target during the previous financial year and were continuing to monitor it on an ongoing basis.

We were told that within Powys Teaching Health Board, all appraisals were up-to-date. Staff we spoke with told us they have regular appraisals which are completed by their operation team leaders. They saw them as positive meetings to help identify further training opportunities to increase continuous professional development.

We found that there was a good level of support in place from the operational team leaders, who we were told made efforts to be visible and approachable to staff within the units. Information provided to us during the course of the inspections demonstrated that they were knowledgeable about their specialist role.

---

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

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

4. What next?

Where we have identified improvements and immediate concerns during our inspections 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 inspections
- 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 inspections 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 inspections 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 inspections

Service: Powys Teaching Health Board

Area: Birth Centres (Free Standing Midwifery Led Units) Across Powys

Date of Inspections: 10 – 14 February 2020

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

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
N/A			

Appendix B – Immediate Improvement plan

Service: Powys Teaching Health Board

Area: Birth Centres (Free Standing Midwifery Led Units) Across Powys

Date of Inspections: 10 – 14 February 2020

Delivery of safe and effective care
During our inspections, we identified concerns relating to patient safety. As a result, we could not be assured that patient safety is maintained in relation to the issues detailed below. The inspection team reviewed the pool evacuation process within the birthing units of Llandrindod Wells, Brecon, Newtown, Llanidloes and Knighton and found that upon speaking with staff that there were inconsistencies in the processes being followed. It was also noted by the inspection team that evacuation equipment such as slide sheets or evacuation nets were not currently in place in all units. We noted that there were inconsistencies in emergency alarm drill testing in all of the units for emergency situations such as a baby/patient requiring resuscitation. When the inspection team tested the process, variance was seen in the emergency team arriving to the birthing units, such as:- • Inability to access the units due to not knowing the access keypad number • Staff arriving to the units without the defibrillation trolley**.**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action it will take to: Ensure that the pool evacuation process is reviewed to ensure safety for women and staff performing the procedure and that staff are fully trained and aware of their responsibility in this area.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care	* Interim Pool Evacuation Policy implemented to provide clarity of process for Evacuation whilst long term plans are being developed * Dry run drills provided to each of the midwifery teams and facebook live demonstration to ensure all staff familiar with updated procedure and use of relevant appendices * Equipment Devises Order Form processed for the purchase of Birthing Pool Evacuation slings and pairs of non-disposable slide sheets 198cm long and flat not a tube * Business plan for the implementation ceiling hoist systems to be purchased over a two-year period for each birth centre with Welshpool Birth Centre as a priority.	Head of Midwifery and Sexual Health Clinical Supervisor for Midwives Head of Midwifery and Sexual Health W&C Business Support	Completed 14th Feb 2020 1 week 21st February 2020 Completed 19th Feb 2020

The health board must provide HIW with details of the action it will take to ensure that: There is an appropriate system in place to ensure that emergency alarm drill testing for emergency situations, such as a baby/patient requiring resuscitation is carried out in line with health board policy and that staff are fully aware of their responsibility within this area.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care	***** Schedule of regular call bell drills * Facilitate community hospital-based emergency call bell drills involving Powys Midwifery Teams & relevant community hospital staff * Powys Midwives to be involved with the development of the site-specific resuscitation plan * Ensure all midwifery staff participate in the regular mock drills carried out within their community hospitals * Seek assurance from all services that where emergency call bell drills	Governance Lead Assistant Head of Midwifery and Sexual Health Resuscitation Committee Head of Clinical Education	Completed 14th Feb 2020 1 – month 12th March 2020 30th June 2020 30th June 2020

		form part of the response to emergencies, that these are effectively undertaken. * Request to the Resuscitation Committee to oversee/review the mock arrest drills in place in all areas across the health board to ensure these involve a multi-professional response from linked areas, for example, general wards supporting birth centres, mental health areas, leaning disability areas and vice versa.	Resuscitation Committee Assistant Director Quality & Safety	30th June 2020 31st March 2020

Health Board Representative:

Name (print): .....Julie Richards / Wendy Morgan …….....

Role: .....Head of Midwifery and Sexual Health / Assistant Director .....

Date: .....20th February 2020.....

Appendix C – Improvement plan

Service: Powys Teaching Health Board

Area: Birth Centres (Free Standing Midwifery Led Units) Across Powys

Date of Inspections: 10 – 14 February 2020

The table below includes any other improvements identified during the inspections 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 the birthing pool facilities are reviewed within the Welshpool Memorial Hospital to increase birthing numbers within the unit.	4.1 Dignified Care	Maternity services are working in partnership with Capital Estates and league of friends for the installation of birth pool facilities for Welshpool Memorial Hospital. Funding has been agreed with League of Friends and pool has been ordered	Women and Children's Business Support	Timeframe delayed for installation due to COVID19 Estates work planned to commence by

Improvement needed	Standard	Service action	Responsible officer	Timescale
				September 2020 and completed by December 2020
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	4.2 Patient Information	The contact details for the Community Health Council are displayed and available in all clinical areas Community Health Council details are provided to clients who raise informal concerns so they are aware of support and advocacy availability The compliance is monitored by Environmental audits by Band 7 Operational Team Leaders	W&C Governance Lead	Complete
Delivery of safe and effective care				
The health board must ensure that escalation and engagement with WAST is reviewed to ensure patient safety in the event of an emergency.	2.1 Managing Risk and Promoting Health and Safety	Maternity services are working in partnership with WAST colleagues for quarterly review of transfer times which have been collated from January 2020		Quarterly review arrangements in place

Improvement needed	Standard	Service action	Responsible officer	Timescale
	3.1 Safe and Clinically Effective Care		W&C Governance Lead	Review September 2020
The health board must ensure that access to PPE within the units is reviewed to ensure infection prevention and control measures are in line with health board policy.	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination 3.1 Safe and Clinically Effective Care	Review of the Birth Centre areas has been undertaken and assurance gained that there is access to appropriate PPE to ensure infection prevention and control measures are in line with health board policy.	Assistant Head of Midwifery and Sexual Health	Complete
The health board must ensure that a review of the facilities within Llanidloes War Memorial Hospital and Knighton Hospital takes place to ensure that infection prevention and control measures are in line with health board policy.	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination	Maternity services are working in partnership with Capital Estates for review of Llanidloes War Memorial Hospital and Knighton Hospital to improve facilities for the environment Plans for Phase 1 (redecoration), 2 (bathroom improvement) and 3 (Pool	W&C Business Support	Knighton programme of work commenced with phase 1 completed. Timescales to be agreed in July Capital

Improvement needed	Standard	Service action	Responsible officer	Timescale
	3.1 Safe and Clinically Effective Care	Hoist insertion and Double Bed) have been developed for Knighton Birth Centre Llanidloes Birth Centre improvement plan to be developed on completion of Welshpool and Knighton project plans.	W&C Business Support	Estate for Phase 2 and 3 work to be completed by March 2021 To present to Capital Estates meeting in September 2020
The health board must ensure that concise record keeping is maintained.	3.1 Safe and Clinically Effective Care	Clinical Supervisor for Midwives discusses documentation standards at group supervision session to ensure concise recordkeeping is maintained The Clinical Supervisor for Midwives also provides monthly recordkeeping audits for staff, where they can review sets of notes and learn directly from any good / poor practice identified in the session. The audit results are fed back at Group Supervisions session	Clinical Supervisor for Midwives	Monthly Monthly

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales to ensure consistency in care.	3.1 Safe and Clinically Effective Care	Women's and Children's Policy and Procedures group has an action plan that lists all policies and guidelines developed, which include revision dates. All policy / guideline authors are approached by the appropriate forums within the Health Board when policy review is required Updated terms of reference for the Women and Children's Policies and Procedures Management for Service Leads for guideline development to meet review dates to enforce and support lines of accountability Monthly Women and Children's Governance meetings are monitoring progress and performance against the Policy and Procedures action plan	Women and Children's Policies and Procedures Management Group Chair Women and Children's Policies and Procedures Management Assistant Director for Women's and Children's Services	Reviewed June 2020 Monthly Completed June 2020 Monthly with review October 2021

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): Julie Richards

Job role: Head of Midwifery and Sexual Health services

Date: 26th June 2020