Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Tirion Birth Centre, Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board

Inspection date: 19 and 20 October 2023

Publication date: 19 January 2024

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Digital ISBN 978-1-83577-462-5

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Tirion Birth Centre, Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board on 19 and 20 October 2023.

During the inspection we invited women and their families to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of three questionnaires were completed by women and three were completed by staff. Whilst feedback and some of the comments we received appear throughout the report, the health board should note that due to receiving only a small number of responses the feedback received may not be representative.

Where present, quotes in this publication may have been translated from their original language.
Our team, for the inspection comprised of two HIW Healthcare Inspectors, two clinical peer reviewers (midwives) and a patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

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

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Staff were observed providing kind and respectful care to women and their families that visited or telephoned the birth centre. We found the staff worked well as a team to provide women and birthing people with a positive experience that was individualised and focussed on their needs. All women and birthing people received their care in a welcoming and homely environment.

This is what we recommend the service can improve:

- Improve the active offer of Welsh for patients
- Consider ways to attract women from diverse backgrounds to use the centre where clinically appropriate.

This is what the service did well:

- Offer of breastfeeding support for women, including those that did not give birth at Tirion
- Homely and welcoming birth environment, with a high standard of furnishing
- Opportunity for women to discuss their birth options available with discussion around risk of options that may be outside of guidance
- Good processes in place to enable women and birthing people, with the opportunity to provide feedback on their care.

Delivery of Safe and Effective Care

Overall summary:

We found robust arrangements were in place to provide women and birthing people with safe and effective care. There were well established processes and audits in place, to manage risk and health and safety. Patient records we reviewed were well organised and promoted appropriate patient choice. We found there were clear processes in place for the management of clinical incidents, ensuring that information and learning is shared across the service.

Immediate assurances, resolved during the inspection:

- There were some improvements that were needed in relation to the safe storage of medicines
- There was a requirement to move an item of clinical furniture to a more appropriate clinical area.

This is what we recommend the service can improve:

- Ensure that a rolling programme of maintenance is in place to enable effective cleaning
- Perform a drill to ensure that mechanisms in place for baby safety continue to be effective.

This is what the service did well:

- An effective system to ensure transfers of care from the Birth centre to the obstetric unit were done in a safe and timely manner
- Effective escalation processes in place to keep women and babies safe
- Comprehensive risk management processes in place.

Quality of Management and Leadership

Overall summary:

We found a positive ethos on the ward, with strong leadership. The staff were very enthusiastic, and committed to providing women and birthing people with a positive experience. A management structure was in place with clear lines of reporting. Midwifery managers were visible and accessible to staff.

This is what we recommend the service can improve:

- Raise awareness of the birth centre outcomes and satisfaction levels with colleagues from across the health board.

This is what the service did well:

- High levels of mandatory training compliance amongst staff
- A robust system in place for tracking patient feedback, and sharing any improvements across the wider maternity services in the health board
- Offering all women, the opportunity to debrief after their birth experience, should they wish.

Details of the concerns for patient's safety and the immediate improvements that were actioned during the inspection are provided in Appendix A.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used online questionnaires to obtain views and feedback from women and families. As there were no inpatient women in the Birth Centre when we inspected, we have reviewed a total of three questionnaires that were completed. Patient comments included the following:

> *"Amazing experience from start to finish. Took notice of extra details that just made the whole time much better and more personal. Midwife and HCA treated me like a friend and looked after me much more than the job requires!"*

> *"Tirion is like a private facility. Care was wonderfully personalised, inclusive of my partner, and respected and valued all of my choices and decisions."*

Person Centred

Health promotion
We reviewed health promotion information that was included in the bedside brochure and displayed within the centre. We also reviewed extensive health promotion information, which related to pregnancy and birth on the Cym Taff Morgannwg University health board website. This included smoking, vaccinations, healthy eating, breastfeeding and exercise information. This information was available in English and Welsh.

We saw that many women accessed breastfeeding support at the birth centre. This support was available for women who did not birth at Tirion as well as those that did.

Dignified and respectful care
The unit was quiet during our inspection and the inspection team were not able to witness face to face care. However, we did see that, throughout the inspection, staff spoke to women that visited the unit with care, kindness and respect. This was also the case with all interactions heard over the telephone.

In Tirion Birth Centre women are treated in well-appointed, homely, modern and clean side rooms with tea and coffee making facilities, double bed and a shared bathroom connecting two rooms. Given that this is a Birth Centre and often partners stay, we asked the staff to describe the systems that were in place to ensure that women's dignity is protected when using the bathroom, assurances and processes were shared and reassurance given.

We noted that medical devises were discreetly hidden in drawers and behind blinds to maintain a homely feel to rooms.

Whilst the rooms were well appointed, we noted that some maintenance was required to some window blinds where some slats were broken / missing. There was also worn paintwork exposing bare wood of units in some rooms. This could make effective cleaning difficult.

The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.

We saw evidence of positive feedback from women and families that have used Tirion Birth Centre, many praising staff at how well they were treated.

All women that answered the questionnaire said that they had been treated with dignity and respect.

Individualised care

Staff we spoke with demonstrated a good awareness of their responsibilities in protecting and promoting patient choice. We saw patient information bedside brochures available in each room . They clearly detailed options for care and empowered women to speak up if their care was not what was expected.
We saw evidence of some patient choice being enabled that was occasionally outside of national guidance and pathways. When requested by women and birthing people, these choices had appropriate written risk assessments, plans and agreements in place. **We saw this as noteworthy practice.**

We spoke with staff members that all confirmed that patient feedback is checked at three different intervals during pregnancy and postnatal care. The feedback was monitored and any issues were address in a timely way. We also saw that patient experience staff members routinely monitored health board social media to ensure that if women were unhappy with their care, then they were able to communicate with a staff member.

All five sets of patient records that we reviewed referred to birth plans and choice.

Timely

Timely care
The centre is open and staffed 24 hours a day and can be accessed by women that meet the health board criteria for birth centre birth.

We were told that women attending the birth centre that request pethidine, may need to wait until the second midwife arrives (if a second midwife was not onsite). This is to ensure compliance with medication management policy and protocol. Women were informed of the potential for a delay with pethidine, should they choose to birth at the centre, although the number of women choosing pethidine as a pain relief in this setting was low.

Staff that we spoke to confirmed that they were able to meet all of the conflicting demands on their time at work.

We reviewed patient care records that confirmed that patients were regularly checked for personal, nutritional and comfort needs.

Equitable

Communication and language
We reviewed signage to Tirion Birth Centre and found clear signage was in place to direct women and families.

Patient information was available in every room in the form of a bedside brochure that detailed important clinical and practical information. It clearly identified staff member role by uniform colour. This information was available in Welsh, on request.

We met with a Welsh speaking member of staff, however there was no way of identifying this staff member, there was no “iaith gwaith” logo on uniforms. We were told that this was due to a uniform issue following return to work from a period of leave.

The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable.

We were told that language line would be used for translation services if women and their families needed. We noted that the website and all information for women was available in English and Welsh.

Rights and Equality

The three women who answered the questionnaire said that had not faced discrimination when accessing or using this health service on grounds of any protected characteristics under the Equality Act (2010).

The staff that we spoke with were all aware of Equality Act (2010) and provided examples where reasonable adjustments were in place, or made, so that everyone, including individuals with protected characteristics, could access and use the service.

We reviewed the staff training records for staff that confirmed mandatory staff training in equality and diversity is in place and compliance levels were high at over 85%.

The birth centre has level access via lift. Wide, clear and uncluttered corridors.

We were told that very few women and families from diverse and minority ethnic backgrounds use the birth centre. We also saw that there was limited information available for non-English speaking women. **The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre.**

Delivery of Safe and Effective Care

Safe

Risk management
We reviewed evidence of regular environmental audits. We saw that any issues were escalated appropriately and records of fault reporting were documented and progress tracked. These processes ensured that risks in the environment were effectively managed to keep people safe.

There was a system for reviewing all transfers of care from the Birth centre to obstetric unit to ensure that practice and transfers were safe, timely and in the patient's best interest. We reviewed documentation that detailed all transfers and monitored each case for lessons learned and / or missed opportunities. We saw that there were regular dynamic risk assessments in place to ensure that women continue to be cared for in the most appropriate settings and any are transferred appropriately.

We discussed the management of incidents with leaders. They described comprehensive processes in place. Any significant incidents were logged immediately, reviewed by senior managers and unit managers and the review was multidisciplinary in nature. This enabled timely learning and any changes in practice to be implemented swiftly. Staff that we spoke to were confirmed that they were confident to report and log incidents and told us of how learning from incidents was shared through staff meetings, WhatsApp group and handovers.

Inspectors reviewed risk assessment documentation and related processes for women wishing to use the birth centre outside of criteria. We noted appropriate measures were in place to enable appropriate choice and minimise risk.

We were informed that there was one registered midwife on shift throughout and the unit would call in further midwife support from community when labouring women came in. There was an appropriate system in place for on call staff and this included flexibility of managers to support clinical work if needed.

We reviewed some policies related to medical emergencies. These were up to date and reviewed regularly.

Staff were able to describe the pool evacuation procedure and equipment used. We were told that training for the management of a maternal collapse in the pool is provided as part of the Community PROMPT study day

Infection, prevention, control (IPC) and decontamination
We found that all areas of the centre were visibly clean, tidy and free from clutter. All women and birthing people who completed a questionnaire said they thought the centre was well organised, clean, and tidy.

We reviewed appropriate and updated policies related to IPC that were available to all staff across the health board via the cloud based IT system.

We saw cleaning schedules for the unit were in place and up to date. Equipment was labelled to show that it was clean and ready for use.

We reviewed evidence on an audit management database related to IPC and confirmed high levels of compliance with recent and regularly performed IPC, hand hygiene audits and unform audits.

We noted that the paintwork on some units in some rooms was worn and exposing the woodwork. This could mean that effective cleaning is difficult. (See improvement in Quality of Patient Experience section)

On the first day of inspection, we saw a suture couch that was being stored in the sluice. We were told that this was rarely used, however this represented an IPC risk as a sluice is not a clinically clean environment. The couch was moved to a more appropriate storage area at the end of the first day.
Further information can be found in Appendix A of this report.

Safeguarding of children and adults
There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Birth centre staff had access to the health board safeguarding procedures via the intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern.

Safeguarding training was mandatory for all staff and we reviewed very high levels of compliance.

We considered the unit environment and found sufficient security measures in place to ensure that babies were safe and secure in the unit. There was a buzzer for entry and airlock exit doors. There were also baby pressure mattresses in use and CCTV camera on the exit doors. We did not review any evidence of a recent

baby abduction drill. Ward leaders confirmed that a baby abduction drill had not been completed in the last 12 months.

The health board must conduct a baby abduction drill at Tirion Birth Centre as soon as possible. Any associated learning from the drill should be shared with staff members.

Management of medical devices and equipment
Overall, staff we spoke with said they had appropriate medical equipment available to them to provide care to women and birthing people. This was confirmed by the staff respondents to the survey where all three agreed that they had adequate materials, supplies and equipment to do their job.

Documentation reviewed confirmed that regular checks on equipment ensured that equipment was suitable for use.

We found the emergency trolley, for use in a patient emergency, was well organised and contained all the appropriate equipment. We noted daily maintenance checks were taking place on this equipment. The emergency drugs were also stored on the resuscitation emergency trolley.

Emergency evacuation equipment was seen within the birth pool room, which could be used in the event of complications during a water birth. We were also assured that all staff had received training in their appropriate use in the case of emergency.

Medicines Management
During the inspection, some issues regarding the safe storage of medication and saline were identified. We identified that the Controlled Drugs register and checks were all in order. However, in order to comply with health board processes, it was required that the keys for the controlled drugs be separated from the main bunch of keys to better control access. This was recommended to leaders and resolved on day one of the inspection with the support of the hospital pharmacy team.

We saw that some fluids were stored in an unlocked cupboard and lignocaine was stored in drawers in birth rooms. Inspectors required the appropriate storage of all medication and fluids in locked cupboards. This issue was addressed and resolved. During the course of the inspection all medicine, fluids and equipment were appropriately secured.

Further information on measures around medication management and security that were resolved during the inspection can be found in Appendix A of this report.

Effective

Effective Care

During the inspection managers were able to assure us that internal audits had taken place and provided the team with evidence of a range of audits and improvements that have taken place. We reviewed the forward audit plan and annual report for 2022-23.

We reviewed evidence of audit activity including IPC and environmental audits that were performed on a regular basis. We saw generally high scores and noted that corrective actions had been taken, tracked and monitored as a result of audits that were completed.

Nutrition and hydration

We did not observe the serving of food during the inspection. In this Birth centre environment, tea and coffee making facilities and water was available in all rooms. Warm food was available via hospital facilities and breakfast available at a time to suit the women. We were told that a selection of sandwiches and snacks were available for women when the needed.

Patient records

We reviewed five sets of patient records. Overall, we found the standard of record keeping to be good with plans well documented.
All records were clear, legible and well organised although in one set of notes there was some missing signatures.

Efficient

Efficient

Tirion Birth Centre is a clean, well appointed, organised and tidy environment. We saw that staff received support from colleagues across the health board area and that they worked together to provide safe and effective care for women, birthing people and families.

We reviewed systems and processes in place to maximise efficiencies. We noted that a number of health board wide specialist roles were in place, including consultant midwives, public health midwife and patient experience midwife. These

staff members supported the staff and women and families that used the birth centre. We were told that specialist midwives and midwifery managers also supported the staffing of the birth centre when necessary.

Quality of Management and Leadership

During the inspection we used online questionnaires to obtain views and feedback from staff. We have reviewed a total of three questionnaires that were completed. One comment received stated

"Tirion is a wonderful safe unit run by experienced midwives who have a passion for midwifery, providing holistic care for pregnant people and their families. We run a happy team who support each other and work hard to cover shifts when needed during times of illness. The families we care for have a positive birthing experience. We pride ourselves on following up any transfers and reflecting on these cases and any learning outcomes. As a team we provide the families and the wider maternity service. Tirion is more than just a workplace it is a second home and we as a team are very proud of it and want to continue promoting its growth."

Leadership

Governance and Leadership
We met with enthusiastic leaders responsible for the Birth Centre that shared a vision for women and families to experience the best possible midwifery led care in a homely environment. Leaders that we spoke with told us of a positive change in culture in recent years, this was confirmed by all staff that we spoke to.

All staff that we spoke to said that their managers could be relied upon and were accessible.

We reviewed documents related to the meetings held to improve services and strengthen governance arrangements. Such meetings included maternity safety and governance meetings, incident review meetings and regular multidisciplinary meetings. Meetings were held regularly, were minuted and actions clearly noted.

During the inspection we reviewed some guidelines and policies and noted that some health board wide policies were out of date for review. This included the Putting Things Right policy which was dated 2011. **The health board should audit, update and share guidelines and policies related maternity care.**

Workforce

Skilled and Enabled Workforce
We witnessed effective communication in place amongst the small number of substantive staff members at Tirion Birth Centre. There is a core staff team of seven to cover the centre.

We were told that the birth centre was fully staffed. Rotas were seen that showed that staffing levels over recent months were fully compliant with Birth Rate Plus. We reviewed the on call rota whereby community midwives support the birth in Tirion Birth Centre. We were told that the Consultant midwife and other specialist midwives cover whole of the health board, and also work clinically to support the Birth Centre.

We reviewed responses from the staff questionnaire and all agreed that they had appropriate training to undertake their role.

We reviewed mandatory training compliance records for the team and confirmed that training compliance for mandatory training is high at over 95%. Training included Community PROMPT training levels high and compliant to ensure that all staff are trained in emergency skills in the event of an obstetric emergency.

We met a newly qualified midwife and we reviewed appropriate induction and training schedules, with support from across the health board throughout a comprehensive preceptorship programme. We noted enthusiasm amongst the team to induct and train the new midwives robustly to ensure new staff feel fully supported.

All staff that we spoke with told us that they have regular appraisals and support to develop, we saw evidence of high levels of annual appraisal compliance.

We were told of a comprehensive range of ways that staff members can feed back any concerns, improvements or suggestions. There was an active Clinical Supervisors for Midwives team. We reviewed the whistleblowing policy. All staff members that we spoke to confirmed that they felt safe to flag concerns or issues with managers.

We saw that there were a range of specialist midwife roles and functions that were in place across the health board. Staff members told us that these roles were visible, supportive and delivering effective and positive outcomes for women and birthing people. Many of these specialist midwives spent time working within the birth centre environment.

We were told that the unit had changed from an obstetric led maternity unit to a midwife led birth unit in recent years. Some staff that we spoke to told us of difficulties in overcoming challenges from some medical colleagues, which related to offering the choice to women that meet the criteria the opportunity to give birth in Tirion (rather than an obstetric led setting).

The health board should raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.

Culture

People engagement, feedback and learning
We saw that the patient bedside brochure clearly detailed ways in which women and families can feedback / raise concerns. We also saw that Putting Things Right information was available for women and families.

We reviewed the wide range of ways in which the health board encourage women to feedback on their experiences. We noted that there were many opportunities for women to feed back on their experiences at different points in their maternity journey. This information was tracked and monitored. We saw that the use of social media supported this work and women were encouraged to join the health board maternity voices group. The systems for tracking of feedback and the using of that feedback to influence changes and improvements in the wider maternity services across the health board is comprehensive. **Inspectors considered this patient engagement and capturing of feedback throughout the maternity journey as notable practice.**

Comprehensive information was reviewed that was given to all women on going home after giving birth. This information included details of how to request a debrief. **This opportunity for women to debrief after birth was also seen as notable practice**.

We saw evidence of how patient feedback has fed into training and awareness raising for staff for example through the “7 minute briefing”.

Feedback boards were displayed with cards and comments from women that have used the birth centre. All staff that we spoke with told us that any concerns or complaints from women and families are encouraged and it was confirmed that there had been no formal or informal complaints received in the last year.

Information

Information governance and digital technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations 2018 within the birth centre. All notes and patient identifiable information was securely stored and away from public areas.

All staff members had access to the secure IT system. We were told that all guidelines can be accessed on a health board wide database that all staff can use.

We were told that the IT system for maternity patient records in the Birth Centre (Royal Glamorgan Hospital) was different from the system in the Obstetric unit (Princess of Wales Hospital) that received Birth Centre referrals. The health board had noted this issue on their risk register due to the risk of miscommunication issues related to women being transferred from birth centre to obstetric unit care. We were informed that plans were in place for both the birth centre and obstetric unit in the health board to change to one streamlined system in summer 2024.

Learning, improvement and research

Quality improvement activities

We were told that there are two research midwives in post in the health board and examples of research activity were shared. This including research related to smoking cessation as well as a feeding study.

Information from Clinical Supervisors for Midwives was reviewed that was aimed at quality improvement.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the 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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Delivery of Safe and Effective Care			
IPC On the first day of inspection, there was suture couch that was being stored in the sluice. We were told that this couch was rarely used, however this represented an IPC risk as a sluice is not a clinically clean environment.	Storage of patient equipment in a sluice is inappropriate due to the IPC risk of a non-clinically clean environment.	Inspector shared concerns with ward lead on day 1 of inspection.	The suture couch was moved to appropriate storage area on day one of the inspection.
Medicines management (controlled drugs keys) We found that the controlled drugs keys were not separate from other keys that were held by the	Hospital process stated that the controlled drugs cupboard key should be	Inspector consulted with ward leaders and pharmacy team on site	The key to the controlled drugs cupboard was separated from the main keys held by the registered midwife on shift.

registered midwife on shift. This was **recommended to leaders and** resolved on day **one** of the inspection with the support of the hospital pharmacy team**.**	separated from the main keys to better secure access to the controlled drugs cupboard and minimise the risk of unauthorised access.	to ensure compliance with health board processes.	
Medicines management (storage) We saw that some fluids were stored in an unlocked cupboard and lignocaine was stored in unlocked drawers in birth rooms. Inspectors required the appropriate storage of all medication and fluids in locked cupboards..	Storing fluids and medication in unsecured cupboards / drawers risks access by unauthorised staff, patients or visitors.	Inspector notified ward leader of unsecured medicine and fluids.	During the course of the inspection all medicine, fluids and equipment were appropriately secured.

Appendix B - Immediate improvement plan

Service: Tirion Birth Centre, Royal Glamorgan Hospital

Date of inspection: 19 - 20 October 2023

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
No immediate improvements requiring a plan were identified				

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Tirion Birth Centre, Royal Glamorgan Hospital

Date of inspection: 19 - 20 October 2023

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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Patient Experience				
Maintenance / IPC Slats on some blinds were broken or missing Paintwork had worn on units in some rooms to expose wood.	The health board should ensure that a rolling programme of maintenance is in place to ensure centre fit for purpose and effective cleaning can take place.	Paintwork has been re-painted. Finance secured and replacement blinds ordered. AMAT environmental audit undertaken monthly. Tirion to be added to the RGH site rolling maintenance programme for paintwork. Environment included within rolling programme of Purposeful Visiting annually.	Senior Lead Midwife Tirion & Community Services	Complete February 2024 Complete Complete

				Complete
Equitable **Active offer of Welsh** We saw that a member of Welsh speaking staff had no iaith gwaith logo We noted that very few women from diverse or minority ethnic backgrounds use the Birth Centre	The health board should consider expanding the active offer of Welsh in the Birth Centre to ensure that Welsh language care is actively offered to women and families and Welsh speaking staff are clearly identifiable The health board should consider ways of improving the awareness of the Birth Centre in diverse communities to increase the diversity of women and families that use the centre	Poster to be displayed depicting iaith gwaith logo up in birth centre areas for service users to identify welsh speakers. Identify all welsh speaking members of Tirion staff to ensure appropriate uniform with iaith gwaith logo. Maternity services digital booking system includes and collects data relating to language/ communications needs and ethnicity to enable the service to understand the diversity within local communities. Implement use of an iPad to support translation and interpreting services for non-English speakers.	Tirion operational lead midwife Tirion operational lead midwife	December 2023 December 2023-February 2024 Complete Complete Complete

		Programme of community-based engagement through Baby Shower events for all prospective service users to attend, which is supported by Tirion birth centre team. Specifically looking at setting up an event in partnership with the University of South Wales to engage with students from overseas.	Early Years Transformation Board, Women's Experience Midwife	March 2024
Delivery of Safe and Effective Care				
Baby safety We noted that a baby abduction drill had not taken place within the last 12 months.	The health board must conduct a baby abduction drill at Tirion Birth Centre as soon as possible. Any associated learning from the drill should be shared with staff members	Updating of the 'Security of the Newborn' guideline in progress, to include auditable standards of an annual baby abduction drill. Baby Abduction drill planned: Table-top baby abduction drill & local baby abduction drill Full baby abduction drill	Postnatal Forum Senior Lead Midwife Tirion & Community Services, Tirion operational lead midwife &	February 2024 December 2023 January 2024

			Security/ Estates teams	
Quality of Leadership and Management				
Awareness of service We received some comments from staff members that we spoke to around the reluctance of some colleagues across the health board to offer the Birth Centre as a choice for women that meet the criteria.	The health board should raise awareness of facilities, outcomes and satisfaction levels of women that have used Tirion Birth Centre with wider colleagues from across the health board.	Annual report of outcomes and experience from Tirion birth centre shared at service-wide audit/governance meeting. Where negativity regarding the model of care is identified, learning via patient story and feedback/reflection by staff is undertaken. Family stories shared at departmental meetings/forums. Tirion 'marketing' video developed and shares family's experiences of using Tirion.		Complete Complete Complete Complete

Policies and guidelines We found that some policies and guidelines that were relevant to the maternity care were out of date or in need of review	The health board should audit, update and share guidelines and policies related maternity care	Current policies/guideline which expired in 2023 have been extended for a further 12 months via the maternity and neonatal improvement Board governance process. Guideline Service Group produces an annual plan of work to ensure timely review of guidelines Staff updated via email and staff social media Comms to ensure awareness of extension of these guidelines. There is a maternity/ gynaecology/ISH guideline group which monitors guidelines which are coming out of date	Head of Midwifery Chair of Guideline Group Intrapartum Lead Midwife Maternity Guideline Group	Complete January 2023 Complete

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): Sarah Fox & Bryany Tweedale

Job role: Head of Midwifery/Gynaecology/ISH, Consultant Midwife

Date: 13th December 2023