Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Maternity Unit, Ysbyty Gwynedd, Betsi Cadwaladr University Health Board

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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 the Maternity Department (including Llifon Ward), Ysbyty Gwynedd, Betsi Cadwaladr University Health Board on 18, 19 and 20 February 2025.

Our team, for the inspection comprised of two Senior HIW healthcare inspectors, three clinical peer reviewers (two registered midwives and a consultant obstetrician) and a patient experience reviewer.

During the inspection we invited women and 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 12 questionnaires were completed by patients or their carers and 56 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Staff were observed providing kind and respectful care to women and their families. We found that all staff at all levels worked well as a team to provide patients with a positive experience that was individualised and focussed on their needs. Almost all patients that we spoke to were positive about their care, the staff and the maternity unit environment. We saw staff delivering patient centred care, and women in labour could access timely pain relief. However, there were some challenges around timely care which need addressing.

This is what we recommend the service can improve:

- Ensuring all women are made fully aware of obstetric treatment choices and their risks and benefits before informed patient consent is gained
- Offering translation services to those women with English / Welsh as an additional language
- Improved pathway for women that may need to use a second auxiliary obstetric theatre.

This is what the service did well:

- Women and families told us that they felt well cared for
- Active offer of Welsh language care
- Comprehensive health promotion information available through the Best Start Hub
- Bereavement support and the Rainbow Clinic
- Birth reflections, opportunity for women to reflect on experiences
- Accessible rooms, wide corridors and welcoming environment.

Delivery of Safe and Effective Care

Overall summary:
We saw arrangements were in place to provide women and birthing people with safe and effective care. There were established processes and audits in place to manage risk, health and safety and infection control.

Patient records we reviewed confirmed daily care planning promoted patient safety. There were some areas of improvement needed around the documentation and decision making related to obstetric intrapartum care, the escalation and use of the

second auxiliary obstetric theatre, as well as the Maternity Obstetric Assessment Unit.

Immediate assurances:

- Communication and handover related to antenatal and intrapartum care were insufficient to enable the planning of safe care for all women and babies.

This is what we recommend the service can improve:

- Ensure that all risks are logged, tracked and mitigated effectively and in a timely manner
- Review and improve the second auxiliary obstetric theatre
- Update guidance and policy around escalation to ensure clarity for staff in the use of the second theatre
- Review and improve systems and processes related to the Maternity Obstetric Assessment Unit (MOAU)
- Ensure all staff are aware of, and act on the recommendations within the Guideline document for Sepsis
- Improve access to documents, medical supplies and equipment
- Review patient records related to intrapartum care to ensure best practice decisions are made and documented and to share learning.

This is what the service did well:

- Safeguarding procedures for women and babies
- Midwifery record keeping
- Medicines management
- Comprehensive clinical audit plan in place.

Quality of Management and Leadership

Overall summary:

A management structure was in place and clear lines of reporting and accountability were described. During the inspection we met with leaders across the maternity service that worked well together. We saw that multidisciplinary working appeared effective throughout the unit. There have been some changes in leadership structure to include roles which are now health board wide, with reporting this impacting on leadership visibility. We noted that compliance with mandatory training in some teams was low.

Immediate assurances:

- Low levels of mandatory training compliance amongst obstetric staff meant that HIW were not assured that all staff that engaged in the delivery of obstetric care had received the relevant up to date training and skills to provide safe care and treatment to all women and babies in their care

This is what we recommend the service can improve:

- Consider and act on all themes and comments from our staff survey
- Address the number of out-of-date policies
- Improve medical staff representation and engagement in relation to incident review and management
- Ensure all staff are aware of learning and actions from incident reviews
- Plan to improve recruitment and retention of medical staff.

This is what the service did well:

- Daily incident review process
- Implementation of Greatix compliments process for staff
- Quality Improvement initiative in relation to caesarean section wounds
- Robust systems and monitoring in place for management of staff, including training, appraisals, sickness absence and vacancies.

Details of the concerns for patients' safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from women and families who have used this service. A total of 12 were received. Overall, many of the respondents rated their experience positively, rating the service as 'very good' (9/12) or 'good' (1/12) sharing comments such as:

> *"We just want to say a big thank you to the team for the support and care we have been given throughout our pregnancy from start to finish. We have had such a positive experience and if we ever come back, we know that we will be in safe hands."*

> *"The midwives have all been lovely, checking on me and my partner. My care has been good so far."*

> *"Big thanks for support and care from start to finish, we have had such a positive experience and we know if we ever came back we would be in safe hands"*

> *"Midwife is so observant …….I really appreciate her as she is so calm, approachable and makes me feel comfortable and safe."*

In addition to the comments received from the completed questionnaires, the inspection team met with women and their families in the unit at the time of inspection. All told us that they were happy and were complementary of the level of care received. Some commended that staff and said that they went "above and beyond" to support women.

Person-centred

Health promotion
We saw health promotion information displayed throughout the unit, this included information on breastfeeding, handwashing and to how to access mental health support. Signage seen confirmed that the unit is a UNICEF Baby Friendly accredited unit.

Staff told us that breastfeeding support was available at the unit with an infant feeding coordinator in post and equivalent breastfeeding support available across the health board.

Comprehensive online pregnancy and pre-conception health promotion information for women and families in the health board area was reviewed as part of the inspection. This health promotion information included the Best Start Hub, which provided advice and support from pre-pregnancy through to early years. This was available in multiple languages. **This Hub of health and wellbeing information was viewed as notable good practice.**

Dignified and respectful care

All women and birthing people, and families that we spoke to during the inspection, and all questionnaire respondents, felt that staff treated them with dignity and respect.

All that answered the HIW questionnaire confirmed that, in their view, patient privacy and dignity was maintained.

The inspection team heard all staff being polite and helpful towards all women and birthing people and their families. Conversations around care were discreet and curtains were closed, although conversations could sometimes be heard because of the layout of bay areas.

We saw evidence of care being delivered in a calm, clean, tidy and welcoming environment and saw women and their families being treated kindly and sensitively throughout the inspection. The inspection team attended maternity ward round where women were able to ask questions and voice their opinions.

A bereavement room was available on the unit for use in the event of an intrapartum death or a stillbirth. This room was within the midwife led unit and situated away from other patient rooms to better support patient privacy and dignity at a very difficult time. The room was supported by significant staff fundraising efforts and provided a comfortable and homely environment. The inspection team noted that the bed was not a hospital bed or on wheels and the room had no piped oxygen. Therefore, if a woman is unwell, she would need to transfer. **The health board must risk assess and ensure appropriate arrangements are in place for timely management of medical emergencies experienced by women using the bereavement room.**

We met with the specialist midwife for bereavement and noted that she provided support for bereaved families as well as staff. Staff confirmed that a Rainbow clinic, a specialist antenatal service, was offered to women who were newly pregnant following a previous pregnancy loss. **This was notable practice.**

A midwife led unit was available for women that met the clinical criteria to give birth in a less medicalised environment. We reviewed the birthing rooms and found these to be well appointed and decorated, with the provision of birthing pools.

Individualised care

Senior managers confirmed that a Patient experience midwife was in post to coordinate and ensure the patient voice was heard and represented in decision making.

Clinical Supervisors for Midwives confirmed that a Birth Reflections service was available to any woman and their partner who has given birth in BCUHB and offered the opportunity to share and reflect on their experiences of maternity services.

A review of patient records confirmed that discussions around labour, birth, pain relief and feeding choices were mostly documented. A staff member commented that:

> *"…The women and their families are treated with great respect and, the vast majority of the time, are included in the planning of their care including times when choices of care might not be considered the best choice..."*

During the inspection, some staff raised concerns around the obstetric team not routinely ensuring that women are making informed choices about their care (consent). This feedback was replicated in some comments made in the staff questionnaire which have been shared directly with maternity leads. Consent and care were discussed with two women within the unit. Both expressed that they were happy with care provided in the community and while in hospital.
The health board must act on comments made by staff as part of the inspection and ensure that all women are fully aware of all obstetric treatment choices, and their risks and benefits before informed patient consent is gained.

There were several specialist midwives in post to support families that needed some additional or specialist support. We spoke with the perinatal mental health midwife, who was within the mental health directorate rather than the Women's directorate. This meant that her time was protected to support midwives in time of high acuity within the maternity department. We saw individualised care and additional care pathways and advocacy for women with difficulties in these and other areas.

Timely

Timely care

Women and birthing people that we spoke with told us that staff were very helpful and would attend to their needs in a timely manner. Staff told us that they would do their best to ensure that all patient needs are met.

Staff comments were mixed in relation to the provision of timely care. Only around half of the staff that answered the questionnaire agreed that they were able to meet all the conflicting demands on their time at work, although around three quarters of staff confirmed that they were satisfied with the quality of care and support given to patients. Feedback from the staff survey was summarised and shared with unit leaders. **The health board must reflect on staff feedback regarding timely care and implement actions to address the issues raised.**

We were told that women in labour could access timely pain relief, Obstetricians confirmed that pain management for women on labour ward is available 24/7 via the dedicated anaesthetists on duty. There were also appropriate options for anaesthetist cover for pain relief in place should the labour ward anaesthetist be in theatre.

Many staff members, at all levels that we spoke with confirmed that there are occasional issues with peaks in acuity and as the unit is small, these peaks can have a higher impact on workloads at that time.

We reviewed some patient records that indicated there may have been delays to clinically appropriate, timely care as a result of a range of issues, including the availability of the main obstetric theatre. The peer reviewer discussed this case with the obstetric team on site and this case was reviewed by a multidisciplinary team to go through the details of the case and to ensure that any lessons learnt were shared.
The health board should review and improve patient flow and experience, especially for those needing theatre based obstetric care.

Equitable

Communication and language

We noted many staff spoke Welsh and we heard Welsh spoken throughout the inspection. Welsh speaking staff members wore the “Iaith Gwaith” logo to identify themselves. Women and birthing people told us that care had been delivered in Welsh. Some commented to say that the active offer of Welsh made a positive impact on their care.

Staff members told us that they used translation services for women and families where English / Welsh was not fluent. However, on review of patient records we saw that, in two sets of notes it was confirmed that translation was required at booking, however, there was no confirmation that this translation was recorded as used.

To ensure that women are fully informed and have given consent, formal translation services should be used when necessary to reduce communication risks. In addition, on review of an incident related to a woman with English as an additional language, it was recorded that no use of translator used. However, this incident was categorised “nothing could be done.”
The health board must review the use of translation services for those women that require it and ensure that this service is available to those women and families that require it.

The health board must consider a review of incidents whereby English / Welsh was not first language and re-consider if they could have been categorised differently.

Rights and Equality

We reviewed the health board's online information, including the Strategic Equality Objectives and Action Plan for 2024-2028, confirming their commitment to equity in health.

All the women and birthing people who answered the questionnaire, and those that we spoke with told us that 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 met a diverse staff team and noted that diversity and equality training was mandatory for all staff, with compliance levels more than 85%.

The unit had level access and accessible rooms, bathrooms and wide corridors to enable easy access for all.

Delivery of Safe and Effective Care

Safe

Risk management
There were some established processes in place to manage and review risks related to health and safety. We were provided with a summary of the Women's Service Risk Register dated February 2025. This detailed the current risks within the unit, when they last reviewed, when they are next due for review and a numerical and Red Amber Green rating. We also reviewed Datix documentation related to the risks. We noted that some of the risks identified throughout the inspection process were logged on the risk register.

There were two theatres on the labour ward for obstetric cases. We were informed that elective caesarean section births took place in one and the second, auxiliary theatre was not often used and was in the entrance to the main obstetric theatre.

The first obstetric theatre was clean, spacious and fit for purpose. On review of the second auxiliary theatre, we noted there were infection prevention and control issues. The layout is small and problematic to deliver obstetric theatre-based care. This theatre appeared to be used for storage purposes. We considered this theatre unfit for purpose.

We noted that the risk register and associated Datix were recently raised (February 2025) in relation to the use of the second auxiliary theatre. Staff told us about concerns around the second auxiliary obstetric theatre have been expressed for several years. The Datix related to the use of the second auxiliary obstetric theatre, which appeared unfit for purpose and used for storage. Some staff reported that women were "queued for theatre" to use the main theatre. Delays in addressing the risks associated with an unfit second theatre could affect the provision of timely care for women requiring emergency obstetric theatre-based care. Some clinical leaders and midwifery managers could not confirm whether the second theatre was listed on the unit risk register.

The health board must ensure that the risk register is updated in a timely way to accurately log and mitigate risks within the service.

The health board must risk assess the suitability of the second auxiliary obstetric theatre and make improvements to ensure that effective IPC is maintained, the layout enables effective emergency obstetric care and that women that need to access theatre based obstetric care receive timely care in a theatre that is safe and fit for purpose.

We reviewed an escalation process document, Managing Emergency Pressures, and staff were able to confirm the process that they would go through in periods of high levels of acuity. Staff told us that Datix would also be used to escalate these incidences. The document did not specify details around the use of the second theatre and we recommend that this is updated so that staff are clear on when to use it.

The health board must ensure that the processes related to the use of the second auxiliary obstetric theatre have been effectively risk assessed, and mitigations implemented to ensure safe, effective and timely emergency obstetric theatre care. A clear policy / guidance must be circulated for escalation in the case of a second obstetric emergency needing theatre-based intervention.

Staff members and leaders within the department confirmed that there were some challenges and risks around the current Maternity Outpatient Assessment Unit (MOAU). The area sees women who fit the BSOTS (Birmingham Symptom Specific Obstetric Triage System) criteria and women who need planned care, e.g. women who need pre-operative assessment or blood pressure monitoring. Two midwives cover the area. Telephone calls are not recorded and are taken in the clinical area. This can cause challenges for midwives managing several different women as well as providing clinical advice and triage on the telephone. We were told that the triage time of 15 minutes is 93%.

The health board must review the activity, staffing and processes related to the MOAU to ensure safe and effective care for all women who contact the service. The health board should consider the following

- **separation of elective and emergency activity**
- **separation of the telephone and the in-person triage process, with a dedicated clinician for telephone triage**
- **recording of calls**
- **Define and implement a formal process for patients that DNA following advice to be seen in MOAU. This will ensure the safety of women and babies**
- **Datix should be completed when women self-discharge and themes for self-discharge and DNA must be collected and audited.**

During the inspection we reviewed the records for one woman where it was indicated that the sepsis pathway should have been triggered. However, the notes documented that blood cultures were not requested, and IV antibiotics were not

commenced, this was outside of the health board sepsis guidance, so the pathway was not followed. Labour ward staff told us that a process 'partial septic screen' was becoming more common and they were concerned that this is not the correct management. They did not feel listened to when they raise concerns about this. The Women's 'Directorate Sepsis Care Pathway Guideline' (including risk assessments) was reviewed, dated October 2022 and is due for next review in October 2025. This document is comprehensive and available to all maternity staff to provide guidance and mitigate risks, given that sepsis remains a risk to health and life for women using maternity services.
The health board must ensure that all staff within the unit including management and leadership are aware of the Guideline document and associated risk assessments and required actions should sepsis pathway be triggered.

We attended both a medical and midwifery handover. Medical handover was in place for intrapartum care and antenatal care. The intrapartum element of handover did not adequately capture those patients undergoing Induction of Labour, nor did it reflect the status of patients on the antenatal ward. There was no formal evidence / documentation that allows an overview and update of patients' status to manage emerging risks effectively**. The issue regarding medical handover was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.**

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

However, as noted earlier, we found the second auxiliary obstetric theatre to be cluttered and appeared to be used to store some equipment.
The health board should review the use of the second theatre as storage and ensure that any non-essential equipment is stored appropriately to improve IPC (see Risk Management section for further improvements related to the second auxiliary obstetric theatre).

We also noted that there were wooden cupboard doors in delivery rooms on labour ward. Some of the wooden doors were chipped and in a poor state of repair. The material and chips made these cupboards difficult to decontaminate. Due to the location of these cupboards, they are at risk of splashes of bodily fluids. The lack of suitable material to allow for effective decontamination represents an IPC risk.
The health board should ensure that difficulties in cleaning woodwork in labour rooms are addressed so that effective IPC can take place.

We observed all staff adhering to the standards of being bare below the elbow and saw good hand hygiene techniques. Handwashing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. Hand hygiene gels were available throughout the unit. We reviewed hand hygiene audits that indicated that a whole audit (start to finish) was rarely completed with audits completed with data missing on some sections. Whilst the results on what had been completed indicated 100% compliance, this figure was based on incomplete audits. **The health board must review an update the process for hand hygiene audits to ensure these are completed in full.**

Safeguarding of children and adults

During the inspection, throughout the unit, we found comprehensive security measures were in place to ensure that families and babies were safe. Access to all areas was restricted by locked doors, which were accessible with a staff pass or by a member of staff approving entrance through an intercom.

We reviewed evidence of a baby abduction drill that took place earlier this year. There was evidence of feedback and learning shared to ensure the continued security of babies in the department.

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 with confirmed they had received training within the past 12 months.

We spoke with a Safeguarding midwife whose role is within the health board safeguarding team. We saw evidence of effective multidisciplinary team working within the unit, during the inspection, when unusual procedures were coordinated and actioned to ensure that the safety of a baby was maintained. These procedures were well planned, appeared to be implemented effectively with minimal disruption to the unit.

All staff that we spoke to were aware of the procedures and processes to follow relating to safeguarding concerns.

Management of medical devices and equipment

During the inspection we reviewed processes and documents related to the required daily checking and monitoring of medical devices and equipment including resuscitaires and defibrillators. We saw that these checks were largely completed and recorded on paper. Details of checks were heard being shared during labour ward handover.

We observed standard equipment in each room, including reusable cuffs, tympanic thermometers and Dopplers. There appeared to be plenty of equipment, but we noted limited storage available. Some midwifery staff we spoke with told us, however, that they did not always have access to essential medical equipment to provide care to patients. This was confirmed by the staff survey, less than half said they have adequate materials, supplies and equipment to do their work (26/56). This posed a risk if prompt observations could not be conducted in a timely manner. One member of staff commented within the questionnaire:

> *"…Stock and equipment is also often an issue with items unavailable for days on end and in short supply, this makes it very difficult to provide timely and effective care and can make the simplest of tasks very difficult..."*

Another staff member told us:

> *"We often run out of fundamental equipment/documents such as sonic aids, ctg stickers."*

The health board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for storage, monitoring and tracking equipment.

Medicines management

We reviewed systems and process in relation to the safe storage and administration of medication. We reviewed medication charts that had been appropriately competed. We saw that legible names or stamps were mostly used.

We saw that medication, including controlled drugs, were safely and appropriately stored and administered. We reviewed records for medication fridge temperature checks and found daily checks were in place.

Effective

Effective care

During the inspection, the senior leadership team 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 saw evidence of the clinical audit plan in place for 2024-25 based on national clinical audits. We also reviewed evidence of comprehensive Tier two and Tier three audits that covered specifics within the maternity unit. Overall, we noted a well-structured approach to clinical audits based on both local priorities and national programmes.

Nutrition and hydration
We observed the serving of a lunchtime meal, and the food looked appetising and was served promptly. Women and birthing people told us that there was good choice. Organisation and coordination around the mealtime were efficient. We saw, in the patient care records we reviewed, that patient nutritional and fluid requirements were well documented.

Patient records
We reviewed eight sets of patient records. Overall, we found the standard of record keeping mixed. We noted some areas of positive practice in relation to midwifery record keeping. This included clear and structured approach to written records in antenatal and postnatal maternity care.

We found that documentation of Obstetric review and care planning required strengthening. Of the eight sets of records reviewed all indicated that there were some deficiencies in intrapartum care.
The health board must ensure that regular documentation audits are robustly conducted, and learning takes place from the findings.

Quality of Management and Leadership

Staff feedback

Responses from staff were mixed. Whilst most were satisfied with the quality of care and support they give to patients (47/56), fewer agreed that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (41/55), or said they would recommend their organisation as a place to work (32/55). Staff comments included:

> *"This unit is small and as a result the team is very close and generally works very well together always prioritising patient care, often before our own wellbeing. The small team we have can be greatly affected by a period of high workload and lack of staff, increasing stress on staff, late working hours, lack of breaks, and as a result more staff absence. A lack of common resources, such as a lack of paper, papers for blood tests, relying on 'photocopied' copies of necessary pathways can all affect workload and staff morale."*

> *"Patients are always the top priority, they're always safe and involved in decision making/consent and their own care plans. Staff on the other hand are not taken seriously, our wellbeing is not top priority, we often feel burnt out, staffing levels feel unsafe at times."*

> *"The teamwork is second to none here we all work well together to provide best care to our women."*

Leadership

Governance and leadership
A clear management structure was in place with clear lines of reporting and accountability. We met with dedicated and supportive midwifery leaders that were aware of areas of good practice as well as areas for development. They shared multiple examples of ways in which they have engaged with staff to provide visibility, engagement and leadership to further develop the unit. We saw effective, welcoming and friendly multidisciplinary working during the inspection and staff told us that team working was a positive feature in this unit.

One comment received from the staff questionnaire noted:

"The teamwork from my clinical colleagues is exemplary and during extremely busy shifts or times of very short staffing they have been amazing pulling together to keep women and their families safe, unfortunately this is not often appreciated by senior management."

Staff confirmed that there had been some changes within midwifery leadership and that newer leadership roles now held responsibility across the whole health board. Some staff told us that they felt this had negatively impacted leadership visibility within the unit. Additionally, feedback from staff regarding senior leaders was mixed. Some told us that senior leaders are not always visible, and some staff we spoke to were not assured that escalation of their concerns was taken seriously.

This was confirmed by responses in the staff questionnaire which stated that most staff (35/56) felt that the senior management were not visible, and just over half told us about that communication between senior management and staff is not effective (33/55).

An anonymised summary of the staff survey has been shared with the health board. **The health board must consider and act on all themes and comments from our staff survey.**

During inspection we were provided with documentation that confirmed around 33% of obstetric guidelines and policies were out of date. This represents a risk to the service and documentation reviewed confirmed that this issue was noted on the departmental risk register.
The health board must develop a robust plan to ensure the timely update and sharing of all guidelines and policies.

We reviewed reports, minutes and agendas that indicated that the service held several regular meetings to improve services and strengthen governance arrangements. Examples of reports reviewed included, Integrated Governance Reports (quarterly) which included incidents details and themes for reporting to the North Wales Service Board. The Women's Directorate Women's Site Meeting West terms of reference and a sample of minutes were also reviewed. These examples show that measures are in place to enhance governance accountability and service improvement.

Themes, trends, actions and learning could be identified from these reports and others provided during the inspection; they could also be described by staff involved in incident reviews. However, staff working in clinical areas were not able to confirm themes, actions and learning from incidents when asked. Additionally, health board medical leadership were also not able to confirm specific themes, trends and learning from incidents from a medical perspective.

The health board must review and enhance the engagement of all staff in the incident review process. It is essential to involve all staff, including medical leadership and interim staff when appropriate, and ensure they are aware about themes and lessons learned from incidents.

We spoke to staff who review Datix incidents daily, noting this timely practice as positive. Staff attendance at these reviews included ward managers, matrons, Head of Midwifery and Midwifery Risk Lead. We noted, however, that the Risk Lead Obstetrician was not routinely involved in this daily review. Consequently, incidents involving breaches of care from a medical point of view may face delays in the learning process without appropriate medical involvement.
The health board should review and update who attends the reviews of daily incident logs for the department and ensure that review process includes the Risk Lead Obstetrician.

When asked how many serious incidents were under investigation, we were told there were 18. We reviewed a recent case that was subject to a rapid review which did not identify any immediate actions. We asked for a log of actions open and overdue, but this information could not be provided. Staff confirmed that actions are not currently on Datix but are recorded separately and on an excel spreadsheet. In addition, we reviewed documentation related to a perinatal death that indicated this was externally reviewed by colleagues within the same health board, albeit from a different location. It is best practice is to ensure that these incidents are reviewed by clinicians external to the health board where they occur.
The health board must improve documented oversight of action management in relation to serious incident reviews to ensure that actions and learning are effectively and swiftly implemented following serious incidents.

The health board must ensure that serious incidents which necessitate external review are reviewed externally by people not employed within the health board and actions and recommendations are swiftly implemented.

Workforce

Skilled and enabled workforce

Throughout the inspection we witnessed staff members working well as a team. We noted examples of effective multidisciplinary working and saw staff at all levels working to attempt to find innovative solutions in sometimes difficult circumstances. Many midwives and doctors that we spoke to were complementary of their team colleagues and the staff questionnaire found that most staff

members (38/56) agreed that their immediate line manager could be counted on to help with a difficult task.

Most staff members told us that they had received a values-based appraisal in the last 12 months, and we reviewed evidence that indicated an 87% compliance rate in January 2025.

In relation to staffing levels, senior leaders that we spoke with during the inspection confirmed that there were specific challenges around recruiting doctors to work in the unit. We were told that recruitment was an issue due to the location. There was higher locum usage in this unit, however, leaders told us that more trainees were available due to gynaecology oncology services located at Ysbyty Gwynedd. During the inspection, interviews were taking place for vacancies within the medical team, and it was hoped that the gaps would be filled.

Many comments from staff confirmed that there was a positive working relationship between doctors and midwives. However, staff that we spoke with told us of the challenges with capacity in obstetric staffing, which they felt was particularly problematic out of hours and often led to delays. Some staff expressed concern that short term locums are not having an induction, and they then carry the responsibility for keeping the unit safe. The staff survey confirmed some of the challenges in relation to obstetric staffing and vacancies.
The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.
The health board must ensure that all staff, including locums and bank staff working within the department complete an appropriate induction.

There was a staffing rota system in place, and we reviewed midwifery rotas that appeared appropriate. Leaders confirmed that the unit is compliant with Birth Rate Plus for midwifery staff, however, many staff felt that there were periods of low midwifery staffing levels and inappropriate skill mix on the unit. This was reflected in their comments both in person and within the staff questionnaire. Midwifery leaders confirmed that there was a Band 6 vacancy that was a response to concerns around skill mix. January monthly absence data reviewed confirmed a sickness rate of 6.28%, vacancies in midwifery at 6.1% and medical vacancies at 17.8%. We noted that there was an acute on call midwife rota in place to support times of high acuity and low staff. Staff and leaders confirmed that this was positive and had been well received.
The health board must reflect on staff feedback around concerns related to low staffing levels and address any causes.

There were effective mechanisms in place to track training levels, appraisal rates, staffing levels and to manage any gaps. We reviewed evidence to confirm that mandatory training levels for midwifery staff was acceptable with compliance at 89% for PROMPT (Practical Obstetric Multi-Professional Training) and 71% for GAP (Growth Assessment Protocol training). Mandatory training compliance levels for medical staff was low at 14% for Basic Life Support, 44% for GAP training and 62% for CTG training.

The issue of low levels of mandatory training compliance for doctors was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Culture

People engagement, feedback and learning

We saw information posters displayed on the unit that included a QR code for women to feedback. Leaders told us that patient feedback was fed back to staff. We saw many Thank You cards displayed throughout the unit. Of note was the Clinical Supervisors for Midwives implemented Greatix initiative. This was put in place to encourage positive feedback to staff that have gone over and above in their work. **This was notable practice**.

We were told that the Maternity Voices group were in place to feedback women's experiences to leaders.

Leaders told us that the staff Facebook group indicated that staff working in the unit were happy and proud.

The Director of Midwifery confirmed that she has an open-door policy for staff to feedback and she meets with Unions, Clinical Supervisors For Midwives and other partners to ensure that she is aware of any concerns within the staff team.

During the inspection leaders were visible and approachable.

Information

Information governance and digital technology

We considered the arrangements for maintaining patient confidentiality and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018 at the practice. It was evident that patient information was stored securely.

Learning, improvement and research

Quality improvement activities

The department Director confirmed that research and quality improvement activities were a priority for the unit. An example was shared related to the reduction of surgical site infections in caesarean section wounds. This work involved standardising sutures and closure methods and resulted in reduced infections.

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
No immediate concerns were resolved during the inspection			

Appendix B – Immediate improvement plan

Service: Maternity Unit, Ysbyty Gwynedd

Date of inspection: 18 – 20 February 2025

Findings

HIW found that medical handover is in place for both intrapartum care and antenatal care. However, the intrapartum element of (medical) handover did not adequately capture those patients undergoing Induction of Labour, nor did it reflect the status of patients on the antenatal ward. There was no formal evidence / documentation in place to allow sufficient medical oversight and the communication of patient status to manage emerging patient safety risks effectively and in a timely manner.

Improvement needed		Standard/ Regulation	Service action	Responsible officer	Timescale
1.	**The health board must ensure that, medical handover between antenatal and intrapartum patient care is:** - **Effective** - **Clearly and routinely documented** - **Communicated during handover.** **This is to ensure that all women across the unit are prioritised effectively and in a timely manner to maintain the safety of mothers and unborn babies.**	Safe	Local Medical Handover process reviewed. A revised Multidisciplinary Obstetric Handover document has been developed to include: • List of all staff in attendance • Maternity and Neonatal unit status • Individual patients on delivery suite (in an SBAR format) • Elective section activity • High risk women on the antenatal and postnatal ward • Women awaiting transfers to delivery suite • Women on other wards including ITU, HDU and outreach wards.	Clinical Lead Clinical Director Clinical Director	31st March 2025 3rd March 2025 3rd March 2025

			A process is in place to archive the revised Handover documentation in line with information governance processes. A new Handover Board has been procured to reflect the revised requirements in the Multidisciplinary Obstetric Handover document. Compliance with this handover process will be monitored weekly at the West Integrated Performance meetings and reported to the Women's Service Senior Leadership Team, QSE, Heath Board Organisational Learning Group and Quality Executive Delivery Group The revised Multidisciplinary Obstetric Handover documentation will be rolled-out Across the other 2 Maternity Units to standardise processes.	Lead Operational Manager Lead Operational Manger/ Matron Clinical Director North Wales Clinical Lead	3rd March 2025 21st March 2025 On-going 17th March 2025

Findings

During our inspection we reviewed staff mandatory training records. The information highlighted a poor compliance of training completion by some obstetricians, which included Basic Life Support (BLS) - 14% compliance, Growth Assessment Protocol (GAP) 44%, and Cardiotocography (CTG) 44%.

We were therefore not assured that all staff providing Obstetric care had completed the required training to maintain the safety of mothers and babies in their care.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale

2.	**The health board must ensure:** • **Obstetricians are supported to undertake and complete mandatory training in a timely manner within Ysbyty Gwynedd and across the health board's maternity services.**	Safe	A medical training compliance review has been completed.	Clinical Director	Completed (26th February 2025)
			Staff will be supported and rostered to attend training sessions as a priority to achieve compliance.	Clinical Director	31st March 2025
			Additional BLS training sessions have been arranged for staff to attend. Two sessions are to be held on 28th March and two sessions on 4th April 2025.	Clinical Director	4th April 2025
			All Clinicians who are not GAP training compliant have been identified and provided with the e-learning link to undertake the training by 31st March 2025.	Clinical Director	31st March 2025
			An Intrapartum Fetal Surveillance (IFS) study day has been arranged for 31/3/25 at Ysbyty Gwynedd. Doctors requiring the training have been rostered to attend. In line with the training requirements medical staff will also be supported to attend the weekly CTG case review meetings.	Clinical Director	31st March 2025
			All new medical staff (including Locum/ Agency staff) that join the service, will be required to supply their mandatory training record from their previous rotation. Any identified training gaps will be included in their induction period prior to commencing clinical practice.	Clinical Director Clinical Director	11th April 2025 On-going
			Mandatory training compliance will be monitored weekly at the Ysbyty Gwynedd		

	• **A risk assessment is completed, and mitigations implemented to minimise the risk of harm and maintain the safety of mothers and babies until training compliance has improved to an appropriate and safe level.**		Integrated Performance meeting and reported to the Women's Service Senior Leadership Team, QSE, Heath Board Organisational Learning Group and Quality Executive Delivery Group In addition, medical mandatory training has been included as a standing agenda item for the departmental monthly meeting where compliance levels will be monitored by the chair. Any compliance risks will be addressed by the Clinical Director. A comprehensive Risk Assessment has been completed which includes specific actions to mitigate any potential risks until compliance has improved to an appropriate and safe level (above 85% compliance). The completed Risk Assessment will be presented to the Women's Services Risk Management Group on 10th March 2025 for inclusion onto the Service's Risk Register which will be regularly monitored and reviewed against the required training and compliance trajectories.	Clinical Director Clinical Director Clinical Director Clinical Director	On-going On-going Completed 10th March 2025

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): Mrs Geeta Kumar

Job role: North Wales Clinical Lead

Date: 27th February 2025

Appendix C - Improvement plan

Service: Maternity Unit, Ysbyty Gwynedd

Date of inspection: 18-20 February 2025

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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	The bereavement room in the Midwife Led Unit area was sometimes used for labour. The bed in this room was not a hospital bed and no piped oxygen was available in the room. There is a risk to women in labour here accessing timely care in a medical emergency.	The health board must risk assess and ensure appropriate arrangements are in place for timely management of medical emergencies experienced by women using the bereavement room for labour.	Standard - Safe	The bereavement room has recently been relocated from labour ward to a more appropriate location on the Midwifery Led Unit. The purpose of the room is to provide a 'home from home' environment with the ability to accommodate partners to stay overnight. The bereavement room is not routinely used for labouring women. All Women are assessed and offered appropriate place of	Head of Midwifery & Gynaecology Nursing	Completed 30th April 2025

				birth. All women are assessed prior to admission and declared medically fit to return to the suite following delivery. On the rare occasion that a woman will spontaneously labour there is a trolley situated outside of the room and portable oxygen, suction, and Entonox available. The service will undertake a Risk Assessment in order to identify the appropriate mitigation in the likely event of a woman labouring in the bereavement room	Bereavement Midwife	31st May 2025
2.	Some staff raised concerns around the obstetric team not routinely ensuring that women are making informed choices about their care (consent).	The health board must act on comments made by staff as part of the inspection and ensure that all women are fully aware of all obstetric treatment choices, and their risks and benefits before	Standard – Person centred	The findings of the report will be shared with the Obstetric team emphasising informed choices and ensuring that these discussions are documented in the maternity records.	Clinical Director/ Head of Midwifery & Gynaecology Nursing	31st May 2025

		informed patient consent is gained.		The Service will be implementing the All Wales PREMS, via Civica, which will enable detailed monitoring in terms of patient experience and will allow national benchmarking.	Consultant Midwife/Patient experience Matron	13th June 2025
				The CIVICA patient feedback for Q4 showed an overall score of 9/10. Feedback on feeling listened to and being involved in decisions about care was scored as 88%. A Patient story which highlighted the importance of using translation services was presented and discussed at key meetings in February 2025.	Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025
				BRAIN (Benefits, Risks, Alternatives, Intuition, do Nothing) cards are given to all women at	Head of Midwifery & Gynaecology	11th July 2025

				booking and newly developed/reviewed Integrated Care Pathways include the tool The tool is discussed at mandatory training sessions delivered by Consultant Midwife (all midwives will have received this training by end July 2025) and during group supervision The consent audit is a BCUHB Tier 2 audit which is commissioned annually by the Office of the Medical Director. The last audit completed by the Service was for 2023, which was presented at the Clinical Effectiveness Group. The 2024 audit has not been commissioned by the Office of the Medical Director at this time.	Nursing/Consultant Midwife Clinical Director/ Head of Midwifery & Gynaecology Nursing	Completed for 2023.

3.	Half of staff that answered the staff questionnaire, told us that they were not able to meet the conflicting demands on their time at work.	The health board must reflect on staff feedback regarding timely care and implement actions to address the issues raised.	Standard - Safe	Maternity Band 7 meetings are held monthly giving staff the opportunity to meet with senior managers and raise concerns appropriately. All meetings have minutes and actions captured.	Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025
				Social media will continue to be utilised as a communication platform to provide update on ongoing improvement projects and outcomes	Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025 and ongoing monitoring
				Clinical Supervisors for Midwives are working with Newly Qualified Midwives to support prioritisation of workload. In addition to this, Clinical Supervisors of Midwives will offer sessions to all Midwives through Group Supervision sessions to address time	Head of Midwifery & Gynaecology Nursing/ Clinical Supervisor of Midwives	Completed 1st October 2024 and ongoing

			management, prioritisation of workload and escalation		
			A Robust Induction Programme package is in place for all new staff to ensure that all training is complete prior to commencing role as a BCUHB employee and support a seamless transition.	Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025
			Recent multi-disciplinary engagement sessions have taken place across all sites in collaboration with Corporate Workforce support. The purpose of these sessions were to identify what was working well and address areas for improvement which included prioritisation of workload. Initial feedback was provided to the Women's Service	Head of Midwifery & Gynaecology Nursing	26th September 2025

			Senior Leadership Team. Final session to take place with Community in June. Feedback will then be provided to all teams identifying themes, trends and recommendations.		
			Team of the Shift has been implemented. Team of the shift intervention is designed to standardise a huddle at the start of every shift prior to clinical handover to promote excellence and teamwork. This enables the Multi-Disciplinary Team to identify priorities, regular discussions, and plans. This is a national MatNeo SS Improvement initiative. The Service will maintain the introduction and	Head of Midwifery & Gynaecology Nursing	Completed 30th December 2024 with ongoing monitoring of compliance

				compliance by on-going audits.		
4.	Some patient records reviewed indicated that there may have been delays in intrapartum care delivery.	The health board should review and improve patient flow and experience, especially for those needing theatre based obstetric care.	Standard - Safe	The Service is currently reviewing delays in second stage of labour and will provide full findings and recommendations in May 2025 to the North Wales Intrapartum Forum with appropriate improvement plans	Head of Midwifery & Gynaecology Nursing	31st May 2025
				The Service will continue to Datix any delays in the second stage of labour. All incidents will be reviewed and findings shared with the Obstetric team via the appropriate antenatal and intrapartum forums.	Head of Midwifery & Gynaecology Nursing	1st May 2025 with ongoing monitoring
				The Service has updated the handover process to ensure a holistic overview of the whole Unit.	Clinical Director	Completed31st March 2025

				The Service completes the Acuity tool utilised on labour ward on a 4-6 hourly basis in order to prioritise workload and manage demand appropriately.	Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025
				An Obstetric Consultant is on Call 24 hrs/ 7 days a week for advice and support. All escalations are managed in line with the Jump Call, Unit Escalation and BCUHB processes. The service will re-circulate appropriate procedures.	Clinical Director	Completed 1st May 2025
				The ACE forms (incident reporting aide-memoire) in use across all three sites to support incident reporting.	Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025
5.	Two sets of patient records reviewed indicated that formal	The health board must review the use of translation services for those women that require	Standard - Safe	The Service is currently undertaking Equality, Diversity, and Inclusivity	Head of Midwifery & Gynaecology Nursing	16th June 2025 and

	translation should be used, however this was not routinely recorded as used.	it and ensure that this service is available to those women and families that require it. The health board must consider a review of incidents whereby English / Welsh was not first language and re-consider if they could have been categorised differently.		competencies in the community. This will be implemented in the inpatient area in May 2025. The Service is updating its documentation to ensure that language preference has been assessed, captured and discussed and that appropriate translation facilities are made available in all circumstances throughout the pregnancy. The Service utilises WITS (Wales Interpretation and Translation Service) to provide translation services to our patients on a 24 hours, 7 days a week basis. Staff will be reminded of the service available.	Head of Midwifery & Gynaecology Nursing Head of Midwifery & Gynaecology Nursing	ongoing monitoring 16th June 2025 Completed 1st May 2025

				Civica feedback provides information around Women's choice. The Service will continue to monitor through Civica feedback the choice of language used to inform Service development and improvements	Head of Midwifery & Gynaecology Nursing	Completed 1st may 2025 and ongoing monitoring
6.	We noted that some long-standing risks were added to the departmental risk register in February 2025 of timely care.	The health board must ensure that the risk register is updated in a timely way to accurately log and mitigate risks within the service.	Standard - Safe	The Service Risks are managed in line with the Health Board's Risk Management Procedure (RM02). Staff will be reminded that risks should be raised and risk assessment progressed in a timely fashion. All Risks are reviewed at the monthly Women's Service Risk Management Meeting and updates submitted to the Corporate Team as required in line with RM02	General Manager General Manager	Completed 1st May 2025 Completed 1st may 2025 and on-going monthly monitoring
7.	The second (auxiliary) obstetric theatre was	The health board must risk assess the suitability of the	Standard - Safe	All equipment in the theatre is essential and	Lead Manager	1st May 2025

	being used for storage and was cluttered.	second auxiliary obstetric theatre and make improvements to ensure that effective IPC is maintained, the layout enables effective emergency obstetric care and that women that need to access theatre based obstetric care receive timely care in a theatre that is safe and fit for purpose.		this has been confirmed by the Lead Clinician in Obstetric Anaesthesia. The Service will undertake an IPC review of the current second theatre to identify and mitigate any risks identified.		
				The Service has undertaken a risk assessment in relation to the suitability of the second obstetric theatre. The assessment and resulting risk has been placed on the Service' Risk Register (ID5493) with a score of 12.	Lead Manager	1st May 2025 and ongoing monitoring
				The Service is working collaboratively with Estates and Planning colleagues to explore the feasibility of alternative options for a second theatre and/or	Lead Manager	30th April 2026

				alterations required. Once the feasibility works have been concluded delivery funding will need to be identified.		
8.	The health board Managing Emergency Pressures document did not specify details around the use of the second theatre	The health board must ensure that the processes related to the use of the second obstetric theatre have been effectively risk assessed, and mitigations implemented to ensure safe, effective and timely emergency obstetric theatre care. A clear policy / guidance must be circulated for escalation in the case of a second obstetric emergency needing theatre-based intervention.	Standard - Safe	The Service has a Protocol for opening of a second theatre and the Management of Simultaneous Obstetric Theatre Cases in place. This will be re circulated amongst the Obstetric Team.	Head of Midwifery and Gynaecology Nursing	Completed 1st May 2025
9.	Staff members and leaders within the department confirmed that there were some challenges and risks around the current Maternity Outpatient Assessment Unit	The health board must review the activity, staffing and processes related to the MOAU to ensure safe and effective care for all women who contact the service. The health board should consider the following	Standard - Safe	The HoM is currently working with the transformation team on an improvement project benchmarking Maternity Assessment Services against the RCOG Green Top Guideline Maternity	Head of Midwifery & Gynaecology Nursing	14th July 2025

	(MOAU). This included layout, how calls are triaged, the assessment of women needing planned care and those needing emergency care.	- separation of elective and emergency activity - separation of the telephone and the in-person triage process, with a dedicated clinician for telephone triage - recording of calls - Define and implement a formal process for patients that DNA following advice to be seen in MOAU. This will ensure the safety of women and babies - Datix should be completed when women self-discharge and themes for self-discharge and DNA must be collected and audited.		Triage Good Practice paper (2023). The service has implemented a standardized system – BSOTS (Birmingham Symptom-specific Obstetric Triage System) which helps ensure consistent and effective assessment and prioritization. Telephone audits have been completed and removal of the telephone has been piloted on one of the three obstetric sites (Central) in North Wales. Findings will be presented at the Women's Board in May 2025 and any recommendations will be actioned and implemented locally on Site.	 Head of Midwifery & Gynaecology Nursing Head of Midwifery & Gynaecology Nursing	 1st May 2025 31st May 2025

				The Service will further review the telephone triage options once the Digital Maternity Cymru programme has been implemented.	Head of Midwifery & Gynaecology Nursing	31st March 2026
				The Service will circulate the Follow up Arrangements for Women Who Do Not Attend Antenatal Appointments and for Women and/or Newborns Where Access is Not Established In The Postnatal Period policy (Mat 22) and ensure data is collected and reported via the Maternity dashboard.	Head of Midwifery & Gynaecology Nursing	31st May 2025
				Reporting patients who self-discharge as an incident on Datix is to be highlighted with staff on the MOAU as being required. It will also be added to the ACE forms	Head of Midwifery & Gynaecology Nursing	31st May 2025

				(incident reporting aide-memoir) currently in use on Labour Wards and Maternity Wards across the 3 sites.		
10.	Review of patient records and staff conversations indicated that the sepsis pathway was not routinely implemented when triggered.	The health board must ensure that all staff within the unit including management and leadership are aware of the Guideline document and associated risk assessments and required actions should sepsis pathway be triggered.	Standard - Safe	Communication regarding the findings will be shared with the multi-disciplinary team. Sepsis is included in the PROMPT programme for this current year running from September 2024-July 2025 and has been included for the past 4 years. A guideline document has been recirculated and added to all safety briefs in the clinical areas for awareness. The All Wales Maternity Early Warning score is in the process of being implemented on the three acute Obstetric Sites in North Wales which supports identification and	Head of Midwifery & Gynaecology Nursing Head of Midwifery & Gynaecology Nursing Consultant Midwife	31st May 2025 31st May 2025 16th September 2025

				escalation of the acutely deteriorating patient as part of the MatNeo SSP Improvement Plan.		
11.	Wooden cupboard doors in delivery rooms on labour ward did not enable effective IPC	The health board should ensure that difficulties in cleaning woodwork in labour rooms are addressed so that effective IPC can take place.	Standard - Safe	The Service is working with Infection Prevention Control and Estates to develop a Business Case to address the IPC issues inclusive of the identified wooden cupboard doors. Funding is to be confirmed.	Estates	26th June 2025
12.	Hand hygiene audit documents reviewed within the unit indicated that audits were rarely completed in full.	The health board must review an update the process for hand hygiene audits to ensure these are completed in full.	Standard - Safe	The Ward Manager has ensured appropriate training for staff undertaking the hand hygiene audit. The Service will continue to audit on a weekly basis to ensure that the proforma is completed in its entirety and fed back to the Local Infection	Ward Manager Ward Manager	Completed 30th April 2025 Completed 30th April 2025

				Prevention Group on a monthly basis.		
13.	Fewer than half of staff survey responses indicated that they had adequate materials, supplies and equipment to do their work.	The health board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for storage, monitoring and tracking equipment.	Standard - Safe	The Service will devise a stock itinerary for each clinical area and adopt a monthly review of all stock to ensure a robust system is in place for the monitoring and tracking of equipment. The Service has upgraded Room 4 on Labour Ward to create a Store Room with purpose built stacking systems. The Store Room on Llifon (In-patient Area) Ward has also been upgraded with appropriate stacking systems in order to ensure adequate stock levels and equipment are maintained.	Ward Manager Ward Manager	31st May 2025 Completed 1st May 2025
14.	Some patient records reviewed indicated that there were some	The health board must ensure that regular documentation audits are robustly	Standard - Safe	Audit of maternity records is completed by all midwives annually as	Patient experience Matron	Completed 30th April 2025 and

	deficiencies recorded in intrapartum care.	conducted, and learning takes place from the findings.		part of their mandatory training. The Supervisors of Midwives also undertakes a rolling audit programme of documentation Obstetric medical records are part of a BCUHB Tier 2 annual audit which is completed by the medical staff on each site. The 2024-25 audit is currently in progress. Midwifery Led Unit Leads complete monthly audit on the All Wales Clinical Pathway for Normal Labour via the Maternity Dashboard.	Patient experience Matron Audit lead for Obstetrics Head of Midwifery and Gynaecology Nursing	ongoing monitoring Completed 1st May 2025 and ongoing monitoring Completed 1st May 2025 and ongoing monitoring through Clinical Effectiveness Group Completed 1st May 2025 and ongoing monitoring
15.	Some staff fed back comments in the questionnaire related to challenges within the unit. (the summary of	The health board must consider and act on all themes and comments from our staff survey.	Standards – Safe, Effective, Efficient, Timely	Appropriate actions have been taken in line with BCUHB Workforce and Organisational Development policies	Head of Midwifery & Gynaecology Nursing	Completed 30th April 2025

	the feedback was shared with the health board)			with support from the Corporate People and Culture Team.		
16.	Staff working in clinical areas were not able to confirm themes, actions and learning from incidents when asked. Additionally, health board medical leadership were also not able to confirm specific themes, trends and learning from incidents from a medical perspective.	The health board must review and enhance the engagement of all staff in the incident review process. It is essential to involve all staff, including medical leadership and interim staff when appropriate, and ensure they are aware about themes and lessons learned from incidents.	Standard - Safe	A 'Theme of the month Board' is situated in the handover room on labour ward and includes significant themes, trends and lessons learnt. Lessons learnt are shared monthly via a Newsletters which is approved at the Women's Quality, Safety and Experience meeting. The newsletter is shared at Site Meetings, Risk Meetings, North Wales Intrapartum Forum, North Wales Antenatal Forum and Local Site Meeting. It is also shared via a closed clinical supervision hub. A quarterly Learning from Incidents Report is	Head of Midwifery & Gynaecology Nursing Risk & Governance Lead Risk & Governance Lead	Completed 30th April 2025 Completed 1st May 2025 and ongoing 31st May 2025

				prepared. The report is shared at Site Meetings, Risk Meetings, North Wales Intrapartum Forum, North Wales Antenatal Forum and Local Site Meeting.		
				All newsletters and quarterly learning reports are uploaded to the Women's Service Governance page on the Betsi-net.	Risk & Governance Lead	31st May 2025
				Datix training is included on the PROMPT programme and this encourages staff to receive feedback from Datix submitted.	Risk & Governance Lead	Completed 1st May 2025 and ongoing
				All staff will be reminded that when reporting an incident, they have the opportunity to indicate as part of the report if they wish to have email feedback.	Risk & Governance Lead	31st May 2025

				Safety briefs are in all clinical areas and these include lessons learnt, safety alerts and all communication required to be highlighted to staff on each shift. The final reports generated from Learning Investigations (SI's) and Perinatal Mortality reviews (PMRTs) are shared with staff involved in the case.	Clinical Lead Midwives/Ward Manager Risk & Governance Lead	Completed 1st May 2025 and ongoing Completed 1st May 2025 and ongoing
17.	Daily review of Datix incidents did not include risk lead obstetrician / any obstetric input.	The health board should review and update who attends the reviews of daily incident logs for the department and ensure that review process includes the Risk Lead Obstetrician.	Standard - Safe	Datix's are reviewed daily by the Multi-Disciplinary Team. The Risk Obstetric Lead is heavily involved with the review process but would not be able to review all incidences daily, all agreed actions are followed up by the appropriate line manager.	Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025

18.	Documentation related to a rapid review of an incident did not identify immediate actions. Any actions from reviews are recorded separately and we were not able to review this action log. Serious incident resulting in a perinatal death was reviewed by health board staff.	The health board must improve documented oversight of action management in relation to serious incident reviews to ensure that actions and learning are effectively and swiftly implemented following serious incidents. The health board must ensure that serious incidents which necessitate external review are reviewed externally by people not employed within the health board and actions and recommendations are swiftly implemented.	Standard - Safe	In the main all actions are completed prior to the report receiving final approval from the Director of Midwifery and Executive Director of Nursing and Midwifery. All actions form initial Learning Reviews, Rapid Review and Final Learning Integration / PMRT reports are added to the Datix incident to support the monthly monitoring of any open actions via the Women's Quality, Safety and Experience Group. All Learning Investigations and Perinatal Mortality Reviews have a minimum of 2 Consultants in attendance, one of	Clinical Governance Lead/ Clinical Governance Midwife Clinical Governance Lead/ Clinical Governance Midwife Clinical Governance Lead/ Clinical Governance Midwife	Completed 1st May 2025 Completed 1st May 2025 Completed 1st May 2025

				which has to be from another site to where the incident occurred. Where it is identified at the initial learning review, that a Consultant from an external organisation will be required for the main review meeting, this is organised with a neighbouring Trust in England. Where a baby has received care from another Trust or Health Board that organisation will be invited to attend the initial and main review which will include a Consultant.	Clinical Governance Lead	Completed 1st May 2025
19.	Staffing Some challenges in recruiting permanent medical staff to the unit were shared.	The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Standard - Safe	The Service will continue to focus on recruitment and retention of medical staff. Rota gaps are filled by Locum or Additional Shift cover to	Lead Manager	Completed 1st May 2025

	Some comments around lack of induction for temporary staff were made.	The health board must ensure that all staff, including locums and bank staff working within the department complete an appropriate induction.		maintain 100% compliance. The Service has implemented a robust induction programme to support staff commencing in new roles and also ensure that competencies have been completed prior to their commencement.	Clinical Director/ Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025
20.	Staff during the inspection and via the staff questionnaire shared concerns around low levels of midwifery and obstetric staffing. (despite documentation reviewed confirming that midwifery staffing is Birth Rate Plus compliant)	The health board must reflect on staff feedback around concerns related to low staffing levels and address any causes.	Standard – Effective	Midwifery staffing is currently Birth Rate Plus compliant. The Service will continue to focus on recruitment and retention of medical staff. Rota gaps are filled by Locum or Additional Shift cover. Staffing status is reviewed on a daily basis by the Senior Leadership Team with oversight provided at	Head of Midwifery & Gynaecology Nursing Clinical Director Clinical Director/ Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025 Completed 31st May 2025 Completed 1st May 2025

				the weekly Matron's meeting. Any gaps are covered by additional staffing. Sickness reviews are managed in a timely manner in line with Health Board Sickness and Absence Policy. Medical, Midwifery and Operational vacancies are reviewed weekly at the West Performance meeting. The Service ensures visible leadership to ensure staff feel supported achieved by daily Matron presence, scheduled HoM/ DoM walkabouts and Senior Leadership presence.	Clinical Director/ Head of Midwifery & Gynaecology Nursing Clinical Director/ Head of Midwifery & Gynaecology Nursing Clinical Director/ Head of Midwifery & Gynaecology Nursing Clinical Director/ Head of Midwifery	Completed 1st May 2025 Completed 1st May 2025 Completed 1st May 2025 Completed

				Staff well-being champions have been appointed in all clinical areas and regularly attend the Women's People and Culture Group in order to escalate any concerns from the clinical area.	& Gynaecology Nursing	1st May 2025
				Clinical supervision sessions focus on supporting staff through high acuity. All Midwives have a minimum of 4 hours per year. These sessions include discussions about resilience and coping strategies for different clinical scenarios. The sessions discussion is often led by staff needs at the time.	Clinical Director/ Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025
				Managing Emergency Pressures in Maternity Unit Escalation Procedure (Mat 84) is in place and subject to	Clinical Director/ Head of Midwifery & Gynaecology Nursing	Completed 1st May 2025

				regular review in line with the DOCG 01 – BCUHB Policy for the Management of Health Board Wide Policies, Procedures & Written Control Document		

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): Karen Roberts

Job role: Head of Midwifery & Gynaecology Nursing Date: 08/05/2025