Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Maternity Unit, University Hospital of Wales, Cardiff and Vale University Health Board

Inspection date: 8-10 November 2022

Follow up Inspection date: 27 – 29 March 2023

Publication date: 21 June 2023

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Digital ISBN 978-1-83504-205-2

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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.

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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 of Maternity Services at University Hospital of Wales, Cardiff and Vale Health Board on 8-10 November 2022. During the inspection, HIW identified several patient safety concerns and we issued an immediate improvement notice on 16 November 2022. HIW undertook a further follow-up inspection on 27 – 29 March 2023.

The following hospital units were reviewed during this inspection:

- Delivery Suite – 14 beds (all single rooms)
- Maternity ward- 40 beds providing antenatal and postnatal care, including 15 transitional care beds and 9 induction of labour beds.
- Obstetric assessment unit- 6 single rooms and a 4 bedded bay
- Midwifery led unit- 4 birth rooms and 5 postnatal rooms
- 3 obstetric theatres
- 2 bereavement rooms.

Our team for the inspection comprised of three HIW Healthcare Inspectors, two clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector. The follow-up inspection comprised of three HIW Healthcare Inspectors, three clinical peer reviewers and one patient experience reviewer.

During the inspection we invited patients or their carers 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 380 (370 in November 2022 and 10 in March 2023) questionnaires were completed by patients or their carers and 207 (152 in November 2022 and 55 in March 2023) 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.

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:
We found that staff worked hard to provide patients with a positive experience despite the pressures on the department. Staff were observed providing kind and respectful care, and patients we spoke to were generally positive of the care they received from staff. However, some patients raised concerns about staff availability and sufficient support. This negatively impacted timely care, and patient dignity and privacy.

An immediate assurance letter was issued following the inspection in November 2022. This related to the experience of a woman being treated differently due to their ethnicity. This was subsequently closed in March 2023 upon receipt of acceptable assurances. Further details of the immediate improvements and remedial actions can be found in Appendix B.

This is what we recommend the service can improve:

- Clearer signage to different areas of the service
- Patients should be cared for within the right clinical areas for their stage in pregnancy
- The induction of labour ward environment should promote patient privacy and dignity
- Women with low risk pregnancies should be given the choice to receive their care in a non-medicalised environment
- Further work needs to take place to support patients from Black, Asian and minority ethnic backgrounds.

This is what the service did well:

- The majority of patients and families told us they felt well cared for
- Women with complex medical issues were well supported
- Patient records we reviewed were comprehensive, and fully documented patient expressed wishes and individual needs
- The active offer of Welsh language maternity care
- The Elan service providing additional support for vulnerable families including women seeking sanctuary
- The bereavement and perinatal services were seen to be very supportive
- Baby Friendly 2022 accreditation had been awarded.

Delivery of Safe and Effective Care

Overall summary:
Patient records we reviewed confirmed daily care planning, which promoted patient safety and evidenced the care provided. However, we raised significant concerns around infection prevention and control, cluttered areas, security and staffing.

We observed good multidisciplinary team working across services such as neonatal, pharmacy, theatres and anaesthetics.

We noted the efficiency improvements in relation to the online booking appointment as well as the automation of some processes that had increased the time available for staff to care for patients.

The following issues were raised in an immediate assurance letter issued following the inspection in November 2022 and subsequently closed in March 2023. Further details of the immediate improvements and remedial actions required are provided in Appendix B:

- We were made aware of incidents where obstetric emergencies had not been responded to in a timely and effective manner. In some of these cases the women and babies had experienced severe and catastrophic harm
- Due to staffing, training, and senior support deficits, we were not assured that staff would be able to respond safely and quickly to emerging patient risk. We were advised of, and observed, specific incidents and issues with care pathways
- The clinical areas and corridors were cluttered with equipment, cleaning equipment, fluids and trolleys
- Insufficient security measures, drills, training and checks were in place to ensure that babies were kept safe and secure
- Hand hygiene audits were not being undertaken on a regular basis with the last audit completed in August 2022
- Other infection prevention and control audit activities were not routinely taking place and the health board could not provide evidence to show that actions had been taken, tracked and monitored as a result of audits that were completed.

A further immediate assurance was issued following the inspection in March 2023 (these included assurances from November 2022 that were not resolved):

- Medicines including controlled drugs were not securely stored in some areas of the unit

- Medicines storage temperatures not routinely monitored in some areas of the unit
- Harmful cleaning fluids were not stored appropriately and safely
- Waste management of sharps was not effectively and safely managed
- Theatre areas (in November 2022) and rooms for care and treatment (in March 2023) were observed to be visibly soiled with what appeared to be blood and bodily fluids
- Routine cleaning schedules were incomplete
- Daily checks of essential maternity equipment including resuscitaires and defibrillators not always recorded
- No timely plans in place to protect the safety and dignity of women and babies in the event of all lifts malfunctioning in the unit
- Insufficient management and security of confidential patient information.

Further details of the immediate improvements and remedial actions required are provided in Appendix C.

This is what we recommend the service can improve:

- Review 24 hour maternity theatre staffing in line with other specialities
- Review and risk assess birth partner use of scrubs / effective PPE when attending theatre for caesarean section
- Ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment.

This is what the service did well:

- Good multidisciplinary team working was seen across services such as neonatal, pharmacy, theatres and anaesthetics
- The efficiency improvements in relation to the online booking appointment and other efficiency savings around automation through the digital midwife had increased the time available for care
- Good health promotion information was available across the unit which included a wide range of relevant services and information
- Patient records documented clinical need as the primary focus of care planning.

Quality of Management and Leadership

Overall summary:
During the follow up inspection in March 2023 we noted some changes within the senior team with a new Divisional Director, plans to recruit Director of Midwifery and the Clinical Director stepping down. We saw the service held regular

governance meetings to improve services and strengthen governance arrangements. Senior managers told us they aimed to be a visible presence on the unit and were making efforts to build up confidence and trust between the unit staff and senior management. Midwifery staff gave positive feedback about their immediate line managers and generally said they could be relied on to help with difficult tasks.

The majority of midwifery staff that we spoke to told us they were struggling to cope with their workloads and poor working environments. Responses to questions on our staff surveys (in November 2022 and March 2023) on the visibility of senior staff, workload and quality of care were very mixed. We saw a small improvement in these responses between inspections. (More information can be found in the Quality of Management and Leadership section of the report).

We had concerns over staffing shortages and in March 2023 it was confirmed that more than £2 million investment will be used to increase staffing levels in the department, all staff that we spoke were optimistic about improvements in staff levels.

We were not assured that there was a supportive culture in place which promoted accountability and safe patient care and that the management and leadership was sufficiently focused and robust. However, during the follow up inspection we noted some improvements related to the investigations process with the appointment of key staff members and allocation of a Clinical Supervisor for Midwives to the investigation process.

The following immediate assurances were issued following the inspection in November 2022 and subsequently closed in March 2023. Further details of the immediate improvements and remedial actions required are provided in Appendix B:

- The units frequently did not have sufficient staff, or sufficient skill mix to maintain basic safety standards
- Serious incident investigations had extended timescales for investigation and the initial reviews did not always pick up important issues for immediate learning
- Poor mandatory training compliance including key clinical skills.

Further details of the immediate improvements and remedial actions required are provided in Appendix B.

This is what we recommend the service can improve:

- Reintroduce team meetings for Maternity Support Workers, band 5 and band 6 team midwives

- Review rota effectiveness for non-clinical midwives to support clinical area
- Effective recruitment and retention processes in place
- Review and improve induction process for band 5 staff
- Adequate breaks or time outs for staff
- Consider necessary action from the less favourable themes and comments in our staff survey
- Review the way in which incidents and concerns are investigated
- Monitor mandatory training.

This is what the service did well:

- Band 7 team members were seen to be supportive and passionate about their role in supporting staff and encouraging continuous professional development
- Research in obstetrics, piloted and led by the health board, now being rolled out across the UK
- Individuals and initiatives within the departments being receiving nominations for awards for best practice
- Efficiency savings for processes to enable time to care
- Clinical Supervisors for Midwives gave good support when workloads enabled this to happen.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we issued both online and paper questionnaires to obtain patient and family views on the service. In total, we received 370 responses. We also spoke to several patients during the inspection.

Patients were asked in the questionnaire to rate the overall experience of the service and around three quarters who answered rated the service as 'very good' or 'good,' and a quarter as 'poor' or 'very poor.' We received 228 comments from patients about their experiences; some comments we received included:

> "I had such a positive experience I wouldn't have changed anything."

> "My birth experience was fantastic and the staff at UHW were brilliant!"

> "The setting was perfect; I gave birth in the midwife led unit and the facilities were above and beyond what I expected… The postnatal room was literally like a home away from home, I had privacy and comfort, didn't feel like a hospital at all."

> "The labour ward were absolutely fantastic. Every single member of staff we encountered there were beyond exceptional. The recovery ward was also fantastic… The postnatal ward was so short staffed, and the … stay I had there was the most traumatic part of the birth experience… The communication re discharge was non-existent…"

> "I feel emotionally scarred by my experience in this hospital."

During the inspection we spoke to a Black patient who told us that they felt they were not listened to or provided with the same level of information or care as other patients. They told us that this had negatively impacted their experience.

We received further comments from the patient questions related to discrimination around ethnicity.

> "It felt that some of the midwives were treating me in a different way because I'm an immigrant"

> "I have wondered since if my experience with the midwife….. was due to my race. I'm a Black British African."

This issue was initially dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report. This immediate assurance was closed during the follow up inspection in March 2023.

During the follow up inspection we reviewed evidence on equality and diversity training for midwives and wider maternity staff. Equality and Diversity training compliance levels were at 80% and this rate had been increasing since November 2022. All staff that we spoke to at all levels, confirmed that there had been initiatives implemented with the aim of improving the safety and experience of Black, Asian and Minority Ethnic women that use the maternity services. Whilst on site we heard the translation machine in active use to improve communication with a patient. We reviewed effective "flash card" resources that were being used in the maternity unit as a communication aid for women that did not speak English. We spoke to women from diverse backgrounds and ethnicities on the days of the inspection who told us that they were happy with the care received.

The specialist service for pregnant women seeking sanctuary as well as the Elan team that provides additional support for some women for example those experiencing mental health problems, young parents and survivors of trauma, were noted as good practice. However, we were told that this service was limited by staff capacity and, due to the additional pressures of delivering training and raising awareness with the wider team, sometimes the service was stretched.

We recommend that the capacity of Elan and women seeking sanctuary services are reviewed in light of team members providing additional training and awareness raising sessions in addition to their clinical work.

All patients that we spoke to during the follow up inspection had high praise for staff and all said that they felt cared for and listened to.

We saw evidence of efficiency improvements and good practice in relation to digital booking appointments and automation of previously staff intensive processes. The work of the digital midwife in these efficiency improvements was commended.

Staying Healthy

Health Protection and Improvement

We saw health promotion information displayed throughout the unit. This included breastfeeding, skin to skin advice, postnatal mental health, and general advice on keeping healthy before, during and after pregnancy.

The hospital was a designated no smoking zone, which extended to the use of vapour/e-cigarettes. We saw appropriate information providing smoking cessation support throughout the unit.

We saw a plaque on the wall stating the unit had achieved UNICEF Baby Friendly accreditation in 2018. We were also advised that the unit had just obtained 2022 accreditation and were awaiting the new plaque for display.

Hand hygiene promotion was seen throughout the unit and also displayed within toilets and kitchen facilities.

Dignified care

Dignified care

During our inspection we witnessed many examples of staff being compassionate and kind to patients and their families. We saw patients being treated with respect and courtesy. Most patients we spoke with were positive about their experiences of care.

We observed the bays in the induction of labour ward. We noted that the close proximity of patients compromised privacy and dignity, and prevented patient confidentiality. Similar patient concerns were raised in our survey:

> *"The induction ward has no privacy, you can hear everything the staff talk about. Not professional."*

The health board should review the induction of labour ward layout and bed spacing to protect confidentiality, privacy and dignity for all service users.

During the follow-up inspection in March 2023 the issue of privacy and dignity continued to cause some concern with some patients that we spoke to. One patient said that she felt vulnerable and uncomfortable in the induction of labour environment.

There were ensuite facilities available in all of the birthing rooms and some postnatal rooms, which helped promote the comfort and dignity of women during

their stay. Where there were no en-suite facilities, shared toilets and shower rooms were available nearby.

There were two dedicated bereavement rooms within the unit. Discussions with staff demonstrated that bereavement care is provided in a timely, sensitive manner. Staff we spoke with said they had received bereavement training and would feel confident in accessing the correct policies to enable them to appropriately care for recently bereaved parents and families.

We were also told about the successful introduction of the Rainbow Clinic, which had been created to care for women and their families who have sadly lost a baby during pregnancy or shortly after birth. The team of midwives and other health professionals support women through their loss, and through the highs and lows of the next pregnancy. Due to the positive impact of this practical and emotional support for women and their families, we were told that this type of service was going to be rolled out across Wales.

We were told that the Health Board is unable to offer intrapartum continuity. Community midwives run antenatal clinics and do not provide intrapartum care. Most of the patients also told us that they were 6 to 12 weeks pregnant when they had their booking appointment. The majority of patients commented positively on choices offered about where to have their baby, however, one comment received within the questionnaires noted:

> *"Give the same priority to women who wish to use midwife led services as those who need to use a labour ward. You're exposing us to more risk!! You have completely scrapped our choices!! My choice was hospital labour ward conveyor belt, or hospital labour ward conveyor belt! Totally unacceptable."*

Senior midwives confirmed that, due to staff shortages, the midwife led unit had been closed on a number of occasions in recent months prior to November 2022. The option for women to have their baby at home had also been removed during the staffing shortages. We were told that this had been done to ensure safe staffing on the main delivery unit. We were assured that these pressures had been mostly resolved due to the recruitment of new midwives, and that patient choice over where to give birth had been restored.

During the follow up inspection we were informed of further challenges in relation to staffing and were told that on occasions patient choice was impacted, although this was happening less frequently than in November 2022. Senior leaders confirmed an investment of over £2 million that would improve the staffing levels in the maternity unit.

We were told of an on-call rota that allocated non-clinical midwives to support the clinical area in times of escalation (short staff / busy department). Most staff were aware of this rota. Some told us that this rota operated 9am – 5pm on Mondays to Fridays and on occasions some allocated staff on the rota were not able to come in.

The health board should review the effectiveness of the on-call rota for non-clinical midwives to ensure it is fit for purpose.

We were made aware of some examples of disparity of care, where, on occasions, low risk women were not in receipt of appropriate midwife led care (for example within the midwife led unit) because of the resources required for high risk women, often from other units that have been appropriately transferred but without additional staffing.

The hospital provided a chaplaincy service and there was a multi-faith hospital chapel for the use of patients and their families. Staff told us about arrangements to enable patients from different faiths to access the prayer rooms to meet their spiritual needs.

Communicating effectively

Overall, patients were generally positive about their interactions with staff during their time in the unit. Most patients who completed a questionnaire in November 2022 said they felt confident to ask for help or advice when required. Most patients also said they had been listened to by midwifery and medical staff during their stay and that staff had spoken with them about their birth choices. These were shared through comments such as:

> *"Excellent care from the midwife who stayed with me for the duration of my labour and delivery. She is an asset to the team and advocated for me…"*
>
> *"Thank you, CAV Midwives and every other healthcare professional, we dealt with... you're all wonderful and do a brilliant job every day!"*
>
> *"Every midwife, nurse or consultant I have seen has been lovely, supportive, informative and helpful."*
>
> *"Staff were really friendly and helpful: I feel listened to and like I have a say in the process."*

However, we received some negative comments regarding staff availability (quotes from November 2022) and support:

> *"The service is clearly under resourced, underfunded and staff need and deserve more to be able to do their jobs to the standard and level they trained for."*
>
> *"I declared that I couldn't cope with negative thoughts and was told it was normal."*
>
> *"Every time I asked for help, I was palmed off with an excuse… I felt like I was inconveniencing them every time I pressed my buzzer…"*

During the follow-up inspection patients at that time told us how they felt well cared for and listened to. We did not hear long waits for call buzzers to be answered and we observed staff speaking to patients kindly and delivering care in a timely manner.

We reviewed a notice board that identified which staff members were on duty.

We reviewed the Cardiff and Vale University Health Board Maternity Services Facebook page and noted that there are 5,900 followers and that maternity information is regularly updated by staff. We also note that when patient reviews of maternity care are posted, staff follow up with the reviewer to thank them. Staff we interviewed told us that the feedback from the Facebook group was very meaningful, but some felt unsure how this data was used to improve services where required.

The health board should consider the comments made by patients in our survey and the social media page, and consider how they can be used to improve services.

Patient information

We checked whether all parts of the unit were easy for patients to locate. Whilst we found the directions to parts of the unit such as the antenatal clinic to be clear, directions to the other maternity wards were not clearly displayed through the hospital. This could make it difficult for people to locate the appropriate place to attend for care. We also noted that the unit is spread widely across the hospital floors, which could be confusing for patients. There were several environmental improvements taking place within the unit at the time of the inspection and we were told that once the work was completed, signage would be clearly displayed.

The health board should improve signage and produce a site map highlighting all areas that provide maternity care in UHW.

During the follow up inspection in March 2023 we saw additional temporary signage in place from the concourse to the main area of the maternity unit. However, not all areas of the maternity unit were clearly signposted or easy to locate. These challenges were confirmed in conversations with patients.

Staff we spoke with were aware of the translation services within the health board and how they were able to access these. Welsh speaking midwives were identifiable by the Welsh speaker logo on their uniform or lanyard. Staff were also aware of the language line facility.

During the follow-up inspection in March 2023 staff told us about further initiatives to promote and support the more frequent use of the "translator on wheels". This unit was available for all patients that needed translation services. The inspection team heard this being used with patients whilst on the maternity unit.

We spoke to one patient who confirmed that she had all intrapartum care and some other maternity care through the medium of Welsh (the patients preferred language). On reviewing a sample of patient records we noted that patient language was recorded on all records reviewed.

We saw that patient at a glance boards were in use and these boards were updated as required and used frequently throughout the day by the multidisciplinary teams to communicate patient safety issues, daily care plans, individual support required and discharge arrangements.

Timely care

Timely Access

The majority of patients told us that staff were very helpful and would attend to their needs in a timely manner. Staff told us they would do their utmost to ensure that patient needs are met.

We observed, and were advised of mixed cohort wards, containing both postnatal and antenatal women, in addition to labouring women. Due to staffing, training and senior support deficits we were not assured that staff in this area were able to respond safely and quickly to emerging patient risk. We were told that staff did not feel confident to escalate and manage women safely, quickly and effectively. The patient pathways were unclear and led to staff working with postnatal and antenatal women in the same areas whilst also managing labouring women.

Some of the patients we spoke to on the postnatal ward indicated that when they required pain relief this was not always given in a timely manner. They felt this was due to staffing shortages and workloads.

The health board should ensure that appropriate pain relief is given in a timely manner.

In March 2023 we saw that, whilst mixed cohort wards with postnatal and antenatal women had reduced, on occasions, this practice continued. We were told that this was mostly due to capacity issues in the unit. It was sometimes essential to ensure that some women with specific accessibility needs were able to receive appropriate and timely care. We were informed of appropriate, daily processes in place to report bed shortages, delays to care due to capacity, low staffing levels and lift malfunction within the maternity unit to senior health board leaders (Gold Command) through the SITREP meeting. This information was assessed by Gold Command alongside Accident and Emergency, ambulance waiting times, Neonatal cots and all other areas of hospital so that decisions were made to mitigate risk of harm for women and babies. Senior staff told us that this had helped to ensure that patient care within the unit was safely managed.

While we understand that due to staffing issues, mixed cohort wards are a necessity to manage risk, the health board should ensure procedures are in place to ensure they are only used as a last resort.

A review of three patient records from unit T2 indicated that appropriate pain relief was given in a timely manner.

We spoke to further staff in March 2023 who confirmed awareness of the escalation processes. Some midwives told us that they were reluctant to escalate further than a Band 7 even if the issue was not effectively resolved. This could present a patient safety risk.

The health board should ensure that all staff are aware of appropriate and safe escalation processes and use these to promote patient safety.

We noted a sepsis screening tool was available which helped to identify patients who may become unwell or develop sepsis. We noted the actions required for a patient with sepsis were displayed in the treatment rooms. We also found that midwives and doctors were quick to recognise the signs of symptoms of sepsis and acted upon in line with national guidelines.

Individual care

Planning care to promote independence

Facilities were easily accessible for patients throughout the unit. In patient notes we saw evidence of continuous assessment of needs with referral to specialist practitioners and support groups as appropriate. Individualised birth plans were documented and included patient expressed wishes and individual needs.

We looked at nine sets of patient records and confirmed that the personal beliefs and religious choices of patients were captured during antenatal appointments.

People's rights

We found that birthing partners could be involved in care in accordance with the wishes and preferences of patients. Records we reviewed confirmed this took place. However, patients we spoke to advised that they were unclear when and where their birthing partners could visit and support. We understand that this may have been due to restrictions in place during the recent Covid-19 pandemic.

Guidance for birthing partners should be effectively communicated during the antenatal period.

Staff also provided examples where reasonable adjustments are in place, or made, so that everyone, including individuals with protected characteristics can access and use the service. We were also told that when required, access to a hearing loop was readily available.

Listening and learning from feedback

Information on the procedure for patients to report concerns or complaints about their care was available on the health board website. The senior management team told us that staff within the unit were aware of how to deal with complaints. Staff we spoke to confirmed this and told us that the Community Health Council details are provided to patients along with Putting Things Right guidance.

Staff told the inspection team that communication with patients and families is maintained throughout any concern received, and families are given the opportunity to meet with senior members of staff to discuss concerns.

Our staff survey asked if patient feedback is collected in their department, and approximately two thirds of the 149 staff who answered agreed. However, one third of those respondents shared that they do not receive regular updates from patient feedback.

The health board should ensure staff are kept informed about service user feedback and commendations.

On review in March 2023, we saw the promotion of QR codes to encourage patients to give feedback to the health board.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety
In general, there were established processes in place to manage and review risks, and to maintain health and safety within the hospital. This assisted staff to provide safe and clinically effective care.

All patient rooms had access to call bells for use in an emergency. The unit mainly appeared appropriately lit and well ventilated. However, we found that clinical areas and corridors were cluttered with equipment, cleaning equipment, fluids and trolleys.

We considered security measures in place to ensure that babies are safe and secure. Access to all areas was restricted by locked doors, which were only accessible with a staff pass or by a member of staff approving entrance. However, upon our arrival to the unit we were given access to the unit without any member of staff asking for identification or enquiring upon the purpose of our visit.

Staff told us the last baby abduction drill was 18 months ago, and we noted the policy states these should be undertaken annually. We were not assured that there was abduction training planned for staff within the unit.

The consultant obstetricians on call either remain in on-site residency or travel to the unit in a prompt and timely manner, however, we were advised by many medical staff that shortages in staffing across the service often had a negative impact on this.

These issue of security above was dealt with under HIW's immediate assurance process and are referred to in Appendix B of this report. This immediate assurance was closed during the follow up inspection.

During the March 2023 follow-up inspection evidence was reviewed that confirmed the completion of two baby abduction drills since November 2022. We saw evidence that learning had been shared and spoke to several members of staff that confirmed this.

We observed a reduction in the amount of equipment, cleaning equipment and trolleys in the corridors throughout the unit. Although some items remained, they were not causing an obstruction or risk to patients and staff.

We saw that cleaning fluids were not safely stored. They were situated in an unlocked utility room in the maternity unit. HIW were not assured that potentially harmful cleaning fluids were stored safely to reduce the risk of unauthorised access.

This issue of cleaning fluid storage described above was dealt with under HIW's immediate assurance process and are referred to in Appendix C of this report.

Three out of the four lifts that served the maternity unit between 27 and 29 March 2023 were out of order. This meant that patients needing emergency transfer to the delivery unit or theatre (floor 2) from other areas of the maternity unit risked delays and lift malfunction of the only remaining functioning lift. An alternative route was described as possible for emergency situations, however, this was a longer route and would take women through public areas of the hospital. HIW are not assured that timely plans are in place to protect the safety and dignity of women and babies in the event of all lifts malfunctioning in the unit.

The issue of swift and safe transfer of patients between areas of the maternity unit in the event of a medical emergency was dealt with under HIW's immediate assurance process and are referred to in Appendix C of this report.

During the follow up inspection in March 2023, we were able to review the theatre environment and staffing levels. We identified a number of challenges and inefficiencies in staffing levels.

- We were told if women had caesarean sections out of normal hours, then they were recovered by midwives rather than specialist theatre staff
- There was a maternity care assistant working as a runner for theatre in addition to their role on labour ward. The distance between the two areas made this dual role inefficient and unrealistic
- One scrub nurse and one Operating Department Practitioner were allocated to theatre, however, good practice would suggest there should be a dedicated theatre team. For example, two theatre scrub nurses, theatre runners and dedicated 24/7 recovery staff.

The health board must review 24 hour maternity theatre staffing in line with other specialities and ensure consistent staffing levels to ensure patient safety.

Preventing pressure and tissue damage

From our review of nine patient records, we found that appropriate checklists were completed, and ongoing risks were monitored.

During the follow up inspection in March 2023, we reviewed a further six sets of patient records and noted that two patient records did not contain completed risk assessments for preventing pressure ulcers, despite being clinically indicated.

The health board should ensure that all relevant risk assessments for pressure and tissue damage are completed when clinically indicated.

Falls prevention
There were risk assessments in place for patients in the unit as well as for those using birth pools. We were told that any patient falls would be reported via the health board electronic incident reporting system.

Infection prevention and control (IPC)
We saw that personal protective equipment was available in all areas and was being used appropriately by all healthcare professionals.

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedures to follow. We saw staff washing their hands and using hand sanitiser when needed. Hand hygiene posters and hand washing guides were on display in patient toilets. We saw that hand hygiene audits were not being undertaken on a regular basis, with the last audit completed in August 2022.

The environment for care and treatment in all areas was visibly tired and dirty. Theatre areas and rooms for care and treatment were observed to be visibly soiled with what appeared to be blood and bodily fluids. This was noted in areas that were not occupied. We noted that there were ripped chairs in use across the unit. We saw that the walls in the maternity unit were marked and dirty and in need of a refresh. We also noted that there was ingrained dirt in the doorways of the lift.

We were also advised that corporate IPC walkarounds and IPC audit activity were not routinely taking place. The unit could not provide evidence to show that actions had been taken, tracked and monitored as a result of audits that were completed. Compliance with IPC training was also low at the time of the inspection.

These issues of cleanliness and IPC were dealt with under HIW's immediate assurance process and are referred to in Appendix B and Appendix C of this report.

During the follow up inspection in March 2023, we saw an improvement in cleanliness in some areas of the unit including theatre, postnatal area, Induction of Labour ward and midwifery led unit. However, we inspected three vacant

(“cleaned” and ready to be used) delivery rooms on the delivery unit on 29 March 2023 and these were visibly dirty. This put women, babies and staff at risk of infection and harm. We noted blood, dirt and stains on the keyboards, floors and around the “cleaned” commodes in all three rooms.

This was concerning as we had previously received assurance from the health board that processes were in place to ensure that the unit is clean. We notified the senior leaders immediately who assured us that immediate action was taken to deep clean these three rooms.

The immediate assurance plan completed by the health board dated December 2022 confirmed that dated labels were to be used to identify that equipment had been cleaned. We did not see any tags in use on any equipment throughout the maternity unit in March 2023.

We reviewed cleaning checklists and confirmed that some of these cleaning checklists were not consistently checked. The cleaning checklists on the Induction of Labour ward were dated November 2022 and no checklist for March 2023 was seen.

We reviewed evidence related to frequent IPC walkarounds and actions, however, given our findings in March 2023, the effectiveness of this process should be improved.

These issues of cleanliness and IPC (updated March 2023) were dealt with under HIW’s immediate assurance process and are referred to in Appendix B and Appendix C of this report.

Further concerns around the safe use of sharps bins were identified during the follow up inspection. On 27th and 28th March 2023 we saw undated and overfull sharps bins throughout the unit. The Sharps Management Procedure described the safe labelling, storage and replacement of sharps contained and we were not assured that the bins were being used in line with health board procedure.

The issues related to sharps bins were dealt with under HIW’s immediate assurance process and are referred to in Appendix C of this report.

During the follow up inspection, our team noted that birth partners that attend the caesarean section delivery of their babies are permitted to attend theatre in their own clothes with limited PPE and without scrubs.

The health board must risk assess birth partner use of scrubs / effective PPE with infection control and update practice to ensure that the safety of patients is not compromised in theatres.

We were told that all patients are tested for Covid-19 prior to or on admission for a booked elective procedure. We confirmed this through seeing test results. We were told that if positive cases were identified, these patients would be isolated accordingly.

Nutrition and hydration
Staff on the wards had access to facilities to make food and drinks for patients outside of core hours and there is a trolley service available for hot meals where patients can pre-order food.

We were told that on regular occasions, women who were booked for elective caesarean sections experienced delays in transfer to theatre, which had a negative effect on the patient safety, experience, and anxiety levels. It also meant that patients who were being fasted in preparation of the procedure and were sometimes being left for prolonged periods without nutrition and hydration.

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report. This immediate assurance was closed during the follow up inspection.

During the follow up inspection, we noted that delays with caesarean sections were monitored on a daily basis and reported via the daily SITREP process to senior leaders to support planning for safe care. We were told by staff members on the unit that the frequency of caesarean section delays had decreased since November 2022, although still occurred on occasions.

Medicines management
We found that there were suitable arrangements for the safe and secure storage and administration of controlled drugs.

Pharmacy support was available to the unit and an out-of-hours computerised system allowed staff to check the stocks of drugs across the hospital to ensure there are no delays in patients receiving medication. There was also take-home medication stock available to facilitate discharges in a timely manner.

We observed drug charts to be generally completed correctly by midwifery and medical staff responsible for administering the medication.

We requested evidence that medication storage fridge temperatures were being checked and recorded on a regular basis. However, we were not provided with any evidence to confirm that all appropriate checks were being completed and logged as required. We therefore could not be assured that temperature sensitive medication was being stored at the temperature advised by the manufacturer, nor that there was a robust system in place to flag any discrepancies.

The health board must implement a robust system to confirm appropriate checks are taken on fridge storage temperatures and actions completed as necessary (updated March 23, added to Immediate Assurance). This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix C of this report.

During the follow up inspection in March 2023, we noted that medicines were stored in unlocked cupboards and a fridge in an unlocked room without swipe card access. We also saw that drugs were not securely stored and left available to patients in one area of the unit.

The daily fridge temperature checks had not always been recorded in line with the health board Medicines Code. This poses a potential risk to patient safety.

The issue of safe storage of medication was dealt with under HIW's immediate assurance process and is referred to in Appendix C of this report.

Safeguarding children and safeguarding adults at risk

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.

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

There was an appointed Lead Safeguarding Midwife for the health board who provided support and training to staff. All staff received safeguarding training that includes guidance regarding female genital mutilation, domestic abuse, sexual abuse, exploitation, and bruises on pre-mobile babies. However, the overall mandatory training rates were poor at the time of the inspection.

During the follow up inspection in March 2023, we noted a significant improvement in the safeguarding training compliance for all staff and were assured that training time was available to staff to complete all mandatory training.

We noted on the follow up inspection that when a Social Services birth plan requires a mother and baby to have 24 hour supervision, this supervision is conducted by ward staff as no Local Authority staff are provided. This can be difficult for staff on duty to fulfil, particularly if there are staff shortages. In order to protect patients and staff 24 hour supervision should be secured from social services.

The health board should work with social services to ensure that 24 hour supervision is provided by social services staff and will not require staff from the maternity unit to deliver 24 hour supervision.

Medical devices, equipment, and diagnostic systems

Staff we spoke to said that they did not always have access to essential medical equipment to provide care to patients. This posed a risk if prompt observations could not be conducted in a timely manner. One member of staff commented within the questionnaire:

> *"Provide more equipment for delivery rooms. This includes, CTG monitoring equipment, BP cuffs and thermometers. At one point we had a shortage of CTG straps and inco pads and which made our job near impossible."*

During the follow up inspection, multiple staff reported a lack of handheld equipment (including sonic aids, dinamaps and antenatal CTG). The staff survey results confirmed this as 85% of those that completed the survey stated that they did not have "adequate materials, supplies and equipment to do their work". Staff told us of delays to patient care and frustrations around time spent looking for handheld equipment to deliver clinical care.

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 monitoring and tracking equipment.

Emergency evacuation equipment was seen within the birthing pool rooms, which could be used in the event of complications arising during a water birth.

We checked the emergency trolley for the use in patient emergencies, and confirmed it was well organised and contained all the appropriate equipment, including a defibrillator. The emergency drugs were also stored on the resuscitation emergency trolley. However, we noted that daily checks of emergency stock and maintenance dates were not consistently taking place on this equipment.

When reviewed during the follow-up inspection, it was disappointing to note that the required daily checks of essential maternity equipment, including resuscitaires and defibrillators had not always been recorded. HIW were not assured that daily checks were taking place to identify equipment faults on equipment that may be needed in an emergency.

This issue was dealt with under HIW's immediate assurance process (updated March 2023) and is referred to in Appendix B and Appendix C of this report.

Effective care

Safe and clinically effective care

We observed staff prioritising clinical need and patient care effectively in the unit at the time of the inspection. We reviewed patient records that demonstrated clinical need was the primary focus of care planning. In general, care planning and treatment was effective, however, we were made aware of an incident where obstetric emergencies had not been responded to in a timely and effective manner. For this incident, our review of medical notes showed that immediate resuscitation appeared to have not been commenced in line with national and local guidelines and standards.

In a case during the first inspection, we were advised by a number of theatre staff of a clinical incident in theatre where a patient may not have received effective post incident clinical checks and follow up in line with recommendations. followed. (More information has been shared with the setting).

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Due to staffing, training, and senior support deficits we were not assured that staff are able to respond safely and quickly to emerging patient risk. We were advised by a number of staff, and observed:

- The management of pathways for antenatal, birth and postnatal patients was inadequate and did not allow staff to feel confident to escalate and manage women safely and effectively

- The pathways were unclear and led to staff working with postnatal and antenatal women in the same areas while also dealing with women in established labour at times. This was also exacerbated by low staffing numbers

- We were told by many staff members that the processes for escalation were not easy to follow, which placed patients at risk. For example, during the course of the inspection, when requested, the inspection team could not be provided with the number of patients that had given birth elsewhere from a delivery suite

- We were made aware of occasions when women were in established labour on the Induction of Labour (IOL) unit and where the staffing level there at that time did not meet the levels required for one-to-one support during established labour. This placed women, babies, and staff at significant risk

- There were significant issues with a lack of neonatal cot availability. This impacted on the ability of the unit to induce and undertake c-sections for safety reasons. This meant that women waiting for elective sections where being delayed for long periods of time, meaning that nil by mouth status was introduced and often the women were left for long periods of time without food or drink

- We asked staff in our survey if they were satisfied with the quality of care and support they were able to give to patients, and 53% of staff responded positively. In relation to being able to provide safe and clinically effective care, almost all of the respondents to the staff survey (95%) said that they were understaffed and 74% felt that they had too many competing priorities.

The issues above were dealt with under HIW's immediate assurance process and are referred to in Appendix B of this report.

During the follow up inspection in March 2023, we noted an improved awareness of escalation procedures to manage patients safely amongst most staff within the maternity unit.

We were told by some doctors and midwives that there had been an improvement in safe staffing levels within the unit and that shortages in staff for shifts were less frequent. Senior leaders confirmed that the increase in funding for more staff should continue to support this.

In the updated staff questionnaire (where 50 staff members responded) 89% of staff disagreed that there are "enough staff at this organisation for me to do my job properly", a small reduction from 95% in November 2022. The March 2023 staff survey indicated that 64% of staff felt that they had too many competing priorities, a reduction of 10% from November 2022.

We asked staff in our March 2023 survey if they were satisfied with the quality of care and support they were able to give to patients, and 60% of staff responded positively an improvement of 7% from November 2022.

We saw evidence of daily SITREP meetings to share unit information with senior leaders within the health board and were told of steps taking to minimise patient risk.

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.

Quality improvement, research and innovation
It was pleasing to see the amount of ongoing research projects and quality improvements taking place in the health board. There were many examples of collaboration with other local health boards on improvement projects such as learning from incidents, and training for student midwives.

We saw a monthly news bulletin where topic matters included thanking staff and news updates.

During the follow up inspection we heard of multiple initiatives and staff members that had been shortlisted for awards.

Information governance and communications technology
The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations 2018 within the unit. Unfortunately, we found notes trolleys were unlocked, and therefore notes were not kept safe and secure, and patient confidentiality was not adhered to.

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

In March 2023 we saw multiple occasions where patient information could have been accessed by passing visitors or other patients. Although, the number of these occasions had decreased since November 2022. HIW were not assured that confidential patient information was stored in line with GDPR.

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

We were told that staff had their own computer access login however we were told by band 5 midwives that they had a significant delay in receiving their log in details.

The health board should improve induction and on-boarding of new staff to ensure that access to computer systems is not delayed.

The follow up inspection noted an improvement in this area and staff confirmed that logins and computer access for staff was not an issue in March 2023.

Record keeping

In addition to reviewing patient records on site, we conducted a further review of four patient records following the inspection. Through these reviews we found evidence of good team working between doctors, midwives, and other multidisciplinary teams. They worked together to help ensure patients received the best care.

Overall, we found the standard of record keeping to be adequate with care plans well documented between multidisciplinary teams. With the exception of the issues outlined above, we saw appropriate observations charts, care pathways and bundles being used.

The standard of documentation, such as completion of ante-natal risk assessments and MEWS and NEWS were completed consistently. Detailed levels of assessments were evidenced in the records we reviewed. However, we did note some inconsistencies in some patient records for example where no signature sheets were seen and in some cases medical signatures were difficult to read.

The health board must ensure that regular documentation audits are conducted and learning takes place from the findings.

During the follow-up inspection we reviewed an additional six sets of patient records. All records were easy to follow which helped to ensure safe and effective patient care. Although on one set of notes the PROMPT chart was not completed and names of clinicians not effectively documented. First names only were documented and no signature on completion of a document related to post-partum haemorrhage. We saw that a separate record did not routinely check on patient mental health despite that patient receiving medication for anxiety and depression.

The health board should ensure that women with mental health problems are routinely asked about their mental health throughout their care.

We noted good practice in relation to the Vaginal Birth After Caesarean (VBAC) form that was completed at first antenatal appointment and repeated at week 36-39.

Quality of Management and Leadership

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total we received 152 completed questionnaires.

Responses from staff were mixed. Just over half said they were satisfied with the quality of care and support they give to patients, and that they would be happy with the standard of care provided by their hospital for themselves or for friends and family. Just under half of the staff recommended their organisation as a place to work.

Almost all respondents, 144 of the 152 staff, felt that there were not enough staff for them to do their job properly. Staff also told us that they do not have enough time to give patients the care they need. We were told:

> *"I am genuinely worried about the risk of harm to women and babies with staffing levels as they have been over the last eighteen months."*
>
> *"We have routinely worked with absence of 25% amongst the midwives for much of the last 10 months and it is unsustainable, and the risks are apparent…"*
>
> *"We struggle when there are not enough staff to care for the amount of women with increasing high-risk needs…"*
>
> *"The unit is so drastically understaffed that things are getting missed, and midwives feel rushed."*

Medical staff advised us that the support they received from their seniors was to a very high standard. However, they considered that the current staffing numbers within the medical team also meant that additional work pressures on staff could cause the environment to be potentially unsafe to work within. Some comments we received through the questionnaires are as follows:

> *"There is excellent MDT working within the unit. Due to the changing nature of maternity care e.g., an increase in induction rate and caesarean sections we no longer have enough bed capacity to cope. The wards are more often than not full which increases pressure on the whole unit. We also lack senior medical cover in areas like the obstetric assessment unit and postnatal wards."*

Staff from different healthcare professions informed us that staffing levels for midwives, medics and ancillary staff regularly fell far below expected and safe levels.

Birthrate plus was in place for establishing midwifery staffing levels. However, we were advised that this was frequently not met due to insufficient and inadequate skill mix. We were provided with examples whereby junior staff were placed in complex situations for which they had not received training and were not sufficiently experienced to deal with. We were made aware that the postnatal area was at times staffed by one midwife instead of two.

In addition to Birthrate plus, we were advised that medical staff frequently had to act into different medical roles due to severe staffing shortages. This included senior doctors to juniors to ensure safe operation of the on-call rota.

We were told that around 30 newly qualified midwives were recently recruited and inducted to the health board. We saw evidence of an induction programme in place for midwifery and medical staff and staff told us that this supported them when commencing in their role. However, this cohort also experienced some delays with computer logins, induction, sufficient uniform and timely salary payments and we were told of poor morale and frustration amongst these staff.

In addition to the practical challenges of induction for 30 new midwives, we were informed that these midwives, in their preceptorship period, were not receiving their full period of support. On occasions, some had been asked to look after student midwives. We were also told of newly qualified midwives being given a full caseload of work. Comments included:

> *"Newly qualified midwives in particular are being pulled all the time to other areas, despite not having had any supernumerary in these areas, and are treated the same as staff who have been there for much longer."*

The health board must review and improve the induction process for new staff.

The issue regarding insufficient staffing (numbers and skill mix) was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

During the follow up inspection in March 2023, HIW repeated the staff questionnaire and received 55 responses. Responses from staff were mixed and some small improvements were seen in some areas.

Notably with just over two-thirds (33/55) being satisfied with the quality of care and support they give to patients, most (41/55) agreeing that they would be happy with the standard of care provided by their hospital for themselves or for friends and family, and over half (30/55) recommending their organisation as a place to work. These figures, whilst based on a lower return rate, represented a small improvement on November 2022.

Governance, Leadership and Accountability

The leadership team in place felt that their support and commitment to the staff was to a high standard, however, interviews with staff provided mixed responses to how valued and supported staff felt by the senior management team. Some staff stated that they felt unsupported during day to day working practices. However, two thirds of staff who completed the questionnaire said that their immediate manager can be relied on to help with a difficult task at work. Staff comments in the questionnaire included the following responses:

> *"… the band 7s are brilliant and very supportive… My line manager is also amazing, and I feel that I can go to them with any issue, and they are always willing to help."*

> *"I believe the band 7 in charge of shifts are working to the best of their ability in extremely challenging circumstances with staffing trying to support us as best they can…"*

> *"… we aren't always getting the support we need on difficult/complex cases as there is no one available to support even if they want to support you."*

Regarding visibility, again responses were mixed and around half of the staff shared within the questionnaire that they considered senior managers are visible. Staff commented:

> *"Senior management are visible and extremely approachable…"*

> *"Senior management are only ever seen if there has been a bad outcome! Very little support to adverse outcomes are offered or given."*

> *"I feel we do not see enough of senior management in practice, on the wards etc. They could be around more and support the unit more in practice."*

The executive team acknowledged that additional work is needed to be undertaken regarding staff culture and improving relationships between staff and

senior management. To bridge the gap between senior management and the unit staff, senior managers told us that they were a visible presence on the unit and were making efforts to build up confidence and trust between the unit staff and senior management. However, it was evident through interviews with staff and from the questionnaires that staff did not always feel valued or supported by senior management. Staff spoke about too many changes in management occurring, and staff found this unsettling.

We were told in interviews that *"Staff are exhausted and finding it hard to work in the current conditions."* We were also told that *"Staff are close to breaking point."*

The health board should consider and act on the theme and comments from our staff survey around visibility, support and feeling valued.

In March 2023 we were told of changes within the senior team with the Clinical Director stepping down and a new Divisional Director being recently appointed (March 2023). There were also plans to recruit a Director of Midwifery.

Some doctors told us of a disconnect between consultants and senior management / executive team. Several doctors told us of concerns around the recognition of specialist skills in the support, development and recruitment of new consultants. We were also told of the continued practice of consultants acting as more junior doctors due to insufficient staffing. Some midwives told us a continued disconnect between clinical midwives and senior management.

The executive team told us of a range of initiatives that had been implemented with a view to engaging with staff improving communication, morale and information sharing. These included (but were not limited to) lunchtime information / question sessions, newsletters, coffee "drop ins." We were told of weekly feedback from the Head of Midwifery on the findings of the "staff voices" initiative and resulting actions. We saw evident of daily Safety Briefings which included lessons learned from incidents, new policies and other updates.

Some staff that we spoke to welcome these initiatives, others told us that they continued to feel disconnected from the senior executives. The staff survey indicated that whilst 80% of respondents knew who the senior managers were, 64% of respondents said that senior managers were not visible. 74% said that communication between senior management and staff is not effective and 74% said that senior managers did not try to involve staff in important decisions. We spoke to staff (doctors and midwives) who said that they were not consulted with or encouraged to contribute to the writing or reviewing guidelines or procedures. Some said that they felt de-skilled with the appointment of specialist staff with

responsibilities for specific areas of clinical work that would otherwise be delivered by more generic staff members. A few staff said that they were encouraged to contribute to positive change in perinatal services.

The health board should consider necessary action from the less favourable themes and comments in our staff survey.

There were defined systems and processes in place to ensure that the maternity unit focussed on continuously improving its services. The senior management team confirmed that actions and recommendations from national maternity audits information is shared. We saw the service held several regular meetings to improve services and strengthen governance arrangements. Such meetings included maternity quality and safety group, maternity and neonatal improvement board meeting, monthly maternity quality and safety group, monthly audit review meeting and weekly multidisciplinary meetings.

The monthly multidisciplinary risk and governance meeting is the forum for discussing and analysing incident reports, managing investigations, learning and implementing actions and changes. However, during all speciality staff interviews we were told that the learning and implementation of improvements was not always seen.

There were significant backlogs in managing and addressing incidents. This meant that learning was not undertaken in a timely and effective way to reduce the risk of reoccurrence.

We noted serious incident investigations had extended timescales for investigation and the initial reviews did not always pick up important issues for immediate learning.

Immediate actions put in place as a result of serious incidents were not always put in place and managed effectively. An example of this was as a result of a recent incident resulting in a catastrophic harm. The review concluded that curtains on the Induction of Labour ward should not be closed around women who were not being monitored. During our inspection we saw that curtains were routinely closed, and women not checked on at sufficient intervals to prevent a reoccurrence.

This issue regarding learning from incidents was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report. This immediate assurance was subsequently closed in March 2023.

All staff we spoke to told us that the organisation encourages them to report errors, near misses or incidents. However, some staff said that they rarely receive

any formal feedback following incidents which would be a missed opportunity for learning and improvement. We were also told by many that the way in which such cases were investigated was of a very punitive nature and it was clear that they felt there was a blame culture.

The health board should review the reporting, investigation and management of concerns and clinical incidents and evaluate the level of support received by staff.

We were told that following a review of incidents, complaints or commendations, a summary of the review and recommendations is discussed at monthly team meetings. Actions are also reported via Daily Safety Briefs. However, during interviews with staff, some indicated that team meetings were not always taking place.

In March 2023 we saw evidence of a fewer “open” significant incidents this had reduced from 30 to 15 between November 2022 and March 2023. We were told that Clinical Supervisors of Midwives were routinely support midwives at the start of any significant incident investigation and most staff that we spoke to told us that this was positive and supportive. We saw evidence that themes were identified and immediate actions taken. All staff that we spoke to felt able to report incidents appropriately.

The health board must ensure that regular team meetings take place, and are a meaningful, supportive and a valuable process for staff.

We found that there was a process in place for monitoring staff attendance and compliance with mandatory training. We reviewed training compliance relating to mandatory training and Practical Obstetric Multi-Professional Training (PROMPT). At the time of inspection, PROMPT training rates were low at 61%. We noted compliance rates with other mandatory training was also not at the required standard. This meant that we were not assured that staff had the relevant up to date training and skills to provide safe care and treatment to patients and babies.

This issue regarding mandatory training was dealt with under HIW’s immediate assurance process and is referred to in Appendix B of this report. This immediate assurance was subsequently closed in March 2023.

We asked staff if in our survey if they had appropriate training to undertake their role and two thirds agreed. Staff told us:

> *“I feel that some training didn’t fully prepare use for our role, for example, not being shown how to use key clinical sites such as clinical*

portal, or how to request blood, as well as not being given access to key equipment…"

"Excellent induction when I started. Had all relevant training."

"The board provide staff with access to often excellent training resources for mandatory or additional training; however, they do not allocate appropriate time for this to be completed, often with the anticipation this will be achieved in our own time. We are often set unachievable deadlines for completion, as no time is allocated in an already increased workload…"

In March 2023 we saw an improvement in training compliance for PROMT and CTG training. Both of these mandatory training areas were at 90% compliance. We spoke to the lead digital midwife and we were assured that live training compliance data is available for all staff in relation to mandatory training. This information is shared with staff daily to prioritise any gaps. Several staff told us of the scheduled time for training starting in April 2023.

We noted blood transfusion training rates were documented at low levels of completion; however, we were assured that the second part of this training was booked for April. 2023.

The health board must monitor all mandatory training rates and prioritise low compliance.

Workforce

We saw there was an escalation process in place for use in times of staff shortages and all staff we spoke to were aware of how to locate the policy and how to escalate staffing issues. However, we were told by many staff that the escalation and concerns were not listened to or acted upon by the senior team or the health board executives.

The health board must ensure that staffing escalation procedures are followed and communicated effectively.

In March 2023 we noted an improvement in awareness of escalation policy related to staffing.

We were told by many staff that there was regularly not time to take sufficient breaks away from clinical areas due to staffing pressures.

In March 2023, the staff feedback comments indicated that many staff remained unable to take sufficient breaks away from clinical area, again citing staffing pressures as the main cause.

The health board must ensure that staff are able to take adequate breaks or time outs during their shifts.

During the inspection we spoke to several student midwives who spoke positively about the support they have received from staff who mentor or support them. However, they also advised on staffing shortages which could on occasion have a negative impact on their learning experience.

The health board must ensure feedback is gained from students to ensure that their training is not affected by matters such as staffing levels.

Staff we spoke with told us they have appraisals. However, some also told us that they did not view the process as meaningful and did not feel these meetings supported their professional development. Staff also reported that there was lack of positive feedback on performance from management.

Staff told us that they did not receive feedback from patient comments about their care from management.

The health board must ensure the appraisal process is evaluated and is meaningful to staff.

The health board is required to feedback service user themes, comments and commendations to staff.

There was a common theme around staff being unable to progress in their role; the majority of staff we spoke to told us that there were limited opportunities for career progression available to them.

The health board must ensure that progression arrangements are evaluated and clearly communicated to staff.

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 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 D: 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 concerns were resolved during the course of the inspections			

Appendix B - Immediate improvement plan (November 2022)

Service: Maternity Unit, University Hospital of Wales, Cardiff and Vale University Health Board

Date of inspection: 8, 9 and 10 November 2022

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.

Quality of patient Experience

Findings

It was reported to us that some women felt they were treated differently due to their ethnicity and skin colour. This was particularly related to women from a Black African background. They felt they were not listened to or provided with the same level of information or care. This meant that the service and health board were not meeting their duty of care to these mothers.

Improvement needed

The health board is required to provide HIW with details of how it will ensure that mothers from diverse backgrounds are not disadvantaged due to their protected characteristics under the Equality Act.

Standard 6.2 Peoples Rights

The Health Board takes equality and diversity very seriously and strives to treat all patients with dignity and respect. Our staff are aware of the specific risks that women of a BAME background have in relation to pregnancy and every effort is made to ensure that they receive equitable care.

The Cardiff and Vale Maternity dashboard links with the Euroking maternity data system and the Perinatal Mortality Review Tool (PMRT) to provide accurate information on outcomes for women, including those from minority ethnic backgrounds. This data has been collected since the publication of the MBRRACE-UK saving Lives, Improving Mothers Care report in 2021 that showed increased mortality rates for women from BAME communities. The data (Redacted) is an example of the maternity dashboard. This data will be presented at the Directorate Quality and Safety Meetings with oversight from the Clinical Board Quality and Safety Meeting to ensure an adequate response.

Data relating to inequalities in outcomes are shared with staff on mandatory training days by our Specialist Midwife for women seeking sanctuary and survivors of harmful practice (appendix 1). Cardiff is the only UHB in Wales to have this specialist role. This specialist midwife supports families from ethnic minorities, supporting them to experience safe and equitable maternity care required, the role is further supported by the ELAN team who provide support to vulnerable families within our communities.

The midwifery mandatory training is in addition to the E-learning modules on ESR. During Covid the additional midwifery mandatory training became virtual E- learning. As Covid-19 restrictions have now eased the face to face training has been reinstated, the programme for this training is included in appendix 2. Training Compliance will be monitored through Directorate and Clinical Board Quality Safety Meetings and reported at the Executive / Clinical Board review.

In April 2023, all staff will receive a week of face to face training to ensure compliance with mandatory and wider training requirements. Until then, staff are being allocated 7.5 hours of protected time to complete their on-line mandatory training. The current compliance rate for equality and diversity training is 70.19% for the 3 yearly mandatory e-learning for obstetrics and gynaecology. By the end of March 2023, it is anticipated that the Obstetrics and Gynaecology Directorate will achieve 90 % compliance.

The specialist midwife also attends Cardiff University to share this data with the undergraduate midwifery students. A number of lunch and learn sessions have also been facilitated by the RCM branch focusing on equality and diversity.

Lead: Consultant Midwife for Public Health **Timescale: Ongoing**

The recent MBRACE report focusing on inequalities in Maternity care will be discussed at the both the Maternity and Clinical Board Quality and safety Meetings in January 2023 and an improvement plan will be developed and will be presented at the Cardiff and Vale UHB Clinical Effectiveness Committee in April 2023.

Lead: Clinical Board Director of Nursing **April 2023**

The Health Board have an existing protocol (appendix 3) to support effective communication with non-English speaking women. Face to face interpreters are used for complex maternity consultations and Language Line is routinely for video consultations.

The Directorate have an interpretation guideline contained within the within maternity services guideline and this has been in place since 2012 and has been included in appendix 4. There is also a locally developed guideline for interpreters in maternity services (appendix 4) this guideline is currently under review; the updated version will be published early 2023. In response to the HIW inspection a Standard Operating Procedure (SOP) (appendix 5) has been developed as a quick reference guide to further support staff when providing care for women where English is not their first language. This has been circulated via email to all staff and laminated copies are available in all clinical areas. The SOP has been ratified via the Maternity Professional Forum and the Gynaecology Professional Forums. Work is ongoing to translate all patient literature into the top five languages. Flash cards are also available in all the areas to support women whose first language is not English.

Every effort is made to recruit women from all communities into the Maternity Service Liaison committee. This forum is key in collecting feedback from service users and in developing services.

Lead: Consultant Midwife for Public Health **Timescale: Ongoing**

The Civica patient experience platform is now in use across the Health Board and QR codes will be displayed in all clinical areas from January 2023. The Platforms support the collection of patient experience information in twelve languages and British Sign Language and all surveys are available in an audio version. Work is being done with Civica to increase the numbers of languages

that surveys can be accessed and submitted in to ensure that the Health Board captures patient experience from all of the communities it serves.

Lead : Assistant Director of Patient Experience **Timescale: January 2023**

In 2023 to date £82k has been spent on the use of interpretation services.

Inclusion ambassadors for the 9 protected characteristics have been appointed to support the services commitment to equality and diversity. The purpose of the Inclusion ambassadors' group is to promote and raise awareness of the protected characteristics as set out in UK law through the Equality Act 2010. The Children and Women's Clinical Board Inaugural Inclusion Ambassador Meeting was held on 21/12/2022 to ratify the terms of reference of the group. The role of the Inclusion Ambassadors is to effectively communicate information to support inclusion and diversity in the workplace, seeking to ensure C&V UHB is a safer, kinder and more inclusive place to receive care and also to work. Each ambassador will engage with the wider protected characteristic group for which they are an Inclusion Ambassador, the UHB Equality Team and 3rd sector Networks in order to bring information back into the Clinical Board for sharing and learning. To communicate key events linked to the protected characteristic and support these where possible in order to reduce inequalities, promote inclusion and respect diversity. The terms of reference and Agenda for the group are included within appendix 6&7

Lead: Director of Nursing for Children and Women Clinical Board

Timescale: Ongoing

Consideration was given to adopting the Web based approach developed in ABUHB in partnership with Public Health to support pre-conception health and delivered through the Healthier Together website. However, it was felt that there might be some constraints to accessing the website amongst some diverse communities. Instead links will be strengthened to engage with women out in our diverse local communities, this will be done through third sector organisations, and links with services and staff we already have collectively with partners.

Lead: Patient Experience Midwife **Timescale: Ongoing**

Delivery of Safe and Effective

Information Governance

Information Governance The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and General Data Protection Regulations (2018) within the unit. We found within the Induction of Labour Ward, that patient information was not being securely managed or stored, to prevent unauthorised access, and to uphold patient confidentiality. This included wheeled patient record trollies containing multiple patient records, which were left unlocked and unmanned. When this was raised with the staff, they advised it was not locked as no one knew the keypad number combination and that it was standard practice to leave the trolley unlocked.

Improvement needed

The health board is required to provide HIW with details of the action taken to provide assurance that documentation is stored in line with GDPR.

Safety briefings have been updated to remind staff of their responsibility to lock notes trolleys when they are not attended (appendix 8). A daily environmental walk round is now undertaken by the senior midwifery team following the HIW inspection and the Tendable audit platform will be used to support ward audit and inspection. An example of the Tendable audit is contained within appendix 9, this is currently being adapted for maternity services. Prior to the introduction of Tendable no formal audit of the note's trolleys were undertaken. Audit results will be reported and monitored through the monthly Quality and Safety Meetings and will be reported to the Clinical Board.

Previous documentation audits focused on the quality of documentation rather than the secure storage. Improvements in the arrangements to safe store of medical records have been made to include lockable trolleys and adherence to this standard is now being audited.

Lead: Deputy Head of Midwifery **Timescale: Ongoing**

Security

The inspection team also considered the security of new-born babies on the delivery suite. We were advised that the last abduction drill had taken place eighteen months ago and assurance was not gained into escalation planning and forthcoming plans of any abduction training for all of the staff within the units.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure measures are in place to ensure that babies are safe and secure across its maternity services to prevent baby abductions

An abduction drill has successfully taken place within the Obstetric led unit on the 18th November and a baby was prevented from being removed from the ward area. The audit report from this drill is contained within appendix 10 and the UHB child abduction policy is in appendix 11. For 2023 an abduction drill will be conducted every quarter, these will alternate between the Obstetric Led Unit and the Midwifery Led Unit. All staff have been reminded of their responsibility to check the identity of all individuals visiting the labour ward to maintain security for mothers and babies' evidence of this is contained within appendix 8.

Lead: Band 7 Operational Leads **Timescale: Ongoing**

Training

Essential mandatory training was not to required standards. This meant that we were not assured that staff had the relevant up to date training and skills to provide safe care and treatment to women and babies. The areas to highlight as concerns are as follows:

- **PROMPT training compliance below 70%. PROMPT training is essential for midwives and other obstetric professionals to be able to respond and deal effectively with a range of obstetric emergencies.**

CTG training statistics were provided but the attendance and compliance for was significantly low at 39%. This meant that over half the staff required to undertake this essential safety training had not received it. This exposed women and babies to an unacceptable level of risk as we could not be assured they were up to date and competent to undertake this duty.

Mandatory training rates were generally low across most subjects. This meant that we are not assured that staff are trained to the required standards to undertake their roles effectively and safely.

We were not assured that staff were provided with specific neonatal resuscitation and emergency management training. This exposes neonates to unacceptable risk of harm and there is a significant risk that babies born requiring resuscitation may not receive timely and effective support.

Improvement needed

The health board is required to provide HIW with details of the action it will take to ensure training is completed in a timely manner and to the recommended health board compliance levels to maintain patient safety.

During the Covid-19 pandemic all face to face training was suspended. Where possible online / virtual learning was developed. This was not possible for PROMPT and an All Wales decision was made to suspend PROMPT. Since the easing of the COVID-19 restrictions all mandatory training study days have been reinstated. Compliance is expected to improve by the end of 2022 to 95%, recognising that individuals on long term absence will not be able to attend. Over the summer months of 2022 short notice cancellation of some study days was required to maintain safe staffing levels with the maternity unit. All cancellations were reported to PROMPT Wales using the appropriate documentation (appendix 12).

The Cardiff and Vale PROMPT programme for 2022/23 is contained within appendix 13.

Please see below for accurate current compliance rates by individual staff groups:

PROMPT Consultant Obstetricians PROMPT training 92% compliant (1 member of staff not yet undertaken refresher course due to long term sick leave).

Medical staff compliance PROMPT training 61% compliant.

PROMPT compliant Midwives 220 of 246 which equates to 89.3% as of December 2022 CTG

The following data represents our current compliance rates:

Consultant Obstetricians 92%, Consultant compliance will be 100% following attendance of our only out of date consultant on a course on 14/12/22. This lapsed is due to long term sickness.

Of our senior tier only one trainee’s training has expired, and the trainee is booked on a course in January.

Our compliance record allows for fulfilment of our local foetal surveillance guideline which mandates that any CTG concerns are reviewed by a ST6 or above.

Midwifery staff 91% face to face full day teaching compliance (225 midwives out of 246).

Since the newly qualified midwives joined the organisation at the end of October 2022 (effective of the rosters from 24th October 2022) additional fetal surveillance study days have been held with a targeted approached for staff that required updates. A newly appointed midwife for fetal Surveillance commenced in post on 14th November 2022 (role profile is contained within appendix 14). Compliance levels will exceed 95% by the end of February 2023. All training compliance will be recorded on Allocate to ensure oversight of compliance levels on every shift. To mitigate for the 10.6% of Midwives that require PROMPT and 9% CTG training.

Lead: Head of Midwifery and Clinical Director **Timescale: Ongoing**

NLS (in house training)

The annual in-house immediate cascade trained Neonatal life support (NLS) is a priority for all midwifery staff providing care to the new-born to allow them to respond to an emergency situation. This training is delivered within the PROMPT study day and compliance is 67.2% amongst midwives. By the end of January 2023, It is anticipated that compliance will be 95%. Twelve NLS cascade trainers have been appointed to provide NLS top up training, plans are in place to train a further six cascade trainers over the next year.

The three yearly advanced Neonatal life support training course is run in house by the resuscitation team, led by two Cardiff and Vale neonatal consultants. This training is prioritised for staff who may undertake neonatal resuscitation outside of the hospital environment and senior midwifery staff. 12.7% of midwives are successfully trained as NLS practitioners following a 1-day intensive training course. The cohort trained include our Intrapartum coordinators and Community Midwives. NLS training was paused during the pandemic.

Commissioned places for the Advanced Neonatal Life Support Training Course have been increased to twenty for 2023/24. Work will continue to increase places for midwifery staff. We will continue to prioritise Community Midwives and Midwifery Led Midwives until there is an increase in commissioning places.

The off duty will continue to recognise NLS trained staff to ensure there are appropriately trained staff in each area.

NLS has been incorporated into both the midwifery professional study day (appendix 15) and the PROMPT programme (appendix 13).

Currently ESR holds UHB mandatory E-learning training records, the Digital Midwife is working with ESR to incorporate all mandatory training for midwives and Obstetricians meaning PROMPT, Fetal Surveillance and NLS will be held on ESR. Every staff member will have one complete training record. This will aid monitoring and compliance checking.

Lead: Digital Midwife **Timescale: Ongoing**

In March 2023 all mandatory training will be incorporated into an annual study week for midwifery staff to ensure high compliance, all staff will be given protected time to attend an off-site course for one week. Off duty management, access to trainers and training facilities mean that it is not possible to commence this approach prior to March 2023. Until the study week starts, staff will continue to attend mandatory study days on their pre-arranged dates and those with on line training requirements will have a protected 7.5 hours to undertake the necessary training.

Lead: Practice development Midwife **Timescale: Ongoing**

<u>Pathways of Care</u>

We were made aware of incidents where obstetric emergencies had not been responded to in a timely and effective manner. In some of these cases the women and babies had experienced severe and catastrophic harm. This included a case whereby (Redacted) .

In another case we were advised by a member of staff that a (Redacted) recommended guidelines were not adhered to following a clinical incident in theatre..

Due to staffing, training, and senior support deficits we are not assured that staff are able to respond safely and quickly to emerging patient risk. We were advised and observed:

• The management of pathways for antenatal, birth and postnatal patients was inadequate and did not allow staff to feel confident to escalate and manage women safely and effectively

The pathways were unclear and led to staff working with postnatal and antenatal women in the same areas while also dealing with women in established labour at times. This was also exacerbated by low staffing numbers.

We were told by many staff members that the processes for escalation were not easy to follow. This placed patients at risk.

We were made aware that when women were in established labour on the Induction of Labour (IOL) unit they were being provided with medication such as pethidine used in established labour. The staffing level there did not meet the levels required for one-to-one support during established labour. This placed women, babies, and staff at significant risk.

There were significant issues with neonatal cot availability. This impacted on the ability of the unit to induce and undertake sections for safety reasons due to lack of availability. This meant that women waiting for elective sections where being delayed for long periods of time, meaning that nil by mouth status was introduced and often the women were left for long periods of time without food or drink.

Improvement needed

The health board is required to provide details to HIW on how it will ensure that women receive safe and timely escalation in the event of deterioration

The health board is required to provide HIW with details of how it will ensure that all women in established labour are identified appropriately and in a timely way to ensure escalation of their care to one to one support.

The Induction of Labour Guidelines (IOL) have recently been reviewed and ratified at the November 2022 Maternity Professional Forum (MPF) MPF minutes can be found in appendix 16 to provide a standardised approach to escalation relating to IOL and this is supported by the development of a Standard Operating Procedure for the Safe and Timely Transfer of Women from the Induction Ward to the Obstetric Lead Unit. In addition, there is a Transfer from the Alongside Midwife Unit Guidance. The monthly guideline update has been shared with all staff and included in the Supervisor for Midwives News Letter (appendix 18).

Oversight of these policies will now be included in all induction training for new staff. All updated policies and protocols are uploaded to the maternity guidelines clinical portal to ensure accessibility. The clinical supervisors for Midwives will provide

development sessions to support the awareness, oversight and understanding of these guidelines and staff will be asked to sign to acknowledge receipt of this update.

During the HIW inspection, staff reported that the pathways for escalation were unclear, in response an Escalation SOP has been developed and shared with all staff (appendix 19). The aim of the SOP is a quick guide for escalation easily accessible to all staff the contents of the SOP is from the 2022 Induction of labour (appendix 17) and highlights that women receiving pethidine on the IOL suite are required to have a pre-pethidine CTG and ongoing monitoring in the form of hourly (Intermittent Auscultation) IA of the Fetal Heart Rate (FHR), This measure has been in place since 2016 as evidenced in the 2021 Induction of labour guideline (appendix 21).

The decision was also made that Entonox is only to be used for difficult vaginal examinations and during the transfer process to delivery suite. Continual use of Entonox can only be used when one to one care is provided. Twice yearly case note audits will be undertaken to assess compliance with these protocols. This has been communicated to staff via email, safety briefing, table top learning via the supervisors for midwives and via the head of Midwifery communication updates.

If there are any delays in care or transfer from the IOL suite then the Midwifery Manager on call must be informed, and it is their role to inform the site manager on call. Details for the on-call teams are now located in all clinical areas for all staff to access should escalation be required. The Escalation SOP works alongside the Maternity Escalation cards / Guideline (appendix 20).

An audit of delays in care is undertaken annually and a retrospective is currently being undertaken reviewing 30 sets of notes. This will be presented at the February Audit and Governance meeting and will continue on an annual basis.

Staff will be reminded that the MEWS charts includes guidance in the reverse of the chart for escalation. Staff will be reminded by email and added to the Safety briefing Information is being collected daily around capacity and staffing within the nonanal unit and maternity unit. This information is escalated to the Site Management and to the Executive Team.

Information is being collected daily around capacity and staffing within the nonanal unit and maternity unit. This information is escalated to the Site Management and to the Executive Team, an example of the daily Maternity Sitrep report can be found in appendix 22. The information is shared with the Executive Director of Nursing, the Medical Director and the Chief Operating Officer, and the Patient Flow Team. The risks are discussed and included in the wider organismal SITREP and the executive team will respond depending on the levels of risk and existing mitigation.

Since November 2022, the SITREPS have been regularly shared with the Executive Team and since that time the new cohort of midwives has commenced in post which has relived some of the staffing pressures. Previously when staffing has been considered to be at an unsafe level decision have been made to shut home birthing services and centralises maternity services.

A daily huddle is undertaken between Obstetric and Neonatal Medical and Nursing / Midwife clinical leads to plan mitigate and escalate risks in a timely manner. The huddles are evidenced in the maternity and neonatal SITREP report.

An Induction of Labour Midwife was appointed in 2022 and their role will include oversight and audit of induction and escalation process. An audit plan will be developed to provide assurance and oversight and audit results will be reported to the Clinical Board QSE meeting. The role profile for the IOL lead midwife can be found in appendix 23.

Lead: Head of Midwifery **Timescale: Ongoing**

Improvement Needed

The health board is required to provide HIW with details of how it will ensure that adequate and appropriate post resuscitation care is delivered in line with national guidelines, to all women and babies requiring any level of resuscitation.

The Health Board does not have its own specific Post Resuscitation Care Policy but uses the UK Resuscitation Council ALS guidelines which also covers posts resuscitation care – Adult Post Resuscitation Care Algorithm 2021. The UHB resuscitation policy will be amended to include the UK Resuscitation Councils guidelines on post resuscitation care.

Lead: Senior Nurse Resuscitation Services **Timescale: February 2023**

PROMPT training includes Maternal Cardiac Arrest. In order to improve the knowledge of post resuscitation care the Advanced Life Support Post Resuscitation Care Algorithm will be included in the Maternal Cardiac Arrest scenario in PROMPT courses. It is important to note that this guideline would not have been applicable to the case that was highlighted during the inspection.

Consideration will also be given to develop a local guideline following chest compression during an intra-operative bradycardia. This is to include a 12 lead ECG and referral to cardiology if abnormal as well as a chest x-ray as indicated for abnormal auscultation or suspected rib fractures. This would have been appropriate care for the case discussed.

Lead: Clinical Director **Timescale: February 2023**

Infection Prevention and Control

Infection control and prevention arrangements to protect women, babies, and staff from risk of infection were inadequate and exposed people to risk of significant harm. We noted:

• The environment for care and treatment in all areas was visibly tired, soiled, and unclean. Theatre areas and rooms for care and treatment were observed to be visibly soiled with what appeared to be blood and bodily fluids. This was noted in areas that were not occupied.

• Environmental audits showed a persistent pattern of noncompliance with essential IPC standards. The rates of compliance were consistently below 80%. We were not provided with any evidence to show that action had been taken, tracked, and monitored as a result of these issues.

• The corridor areas were cluttered with equipment and detritus. Cleaning fluids and trolleys were left out and unsecured. This posed significant risk of harm to anyone visiting the unit.

• Hand hygiene audits were not being undertaken regularly. The last audit was undertaken in August 2022.

Improvement needed

The health board is required to provide HIW with details of how it will ensure that women and babies are protected from avoidable infections.

In response to HIW findings the Rapid Response Housekeeping Team undertook a programme of enhanced cleaning throughout all areas of the maternity and obstetric clinical footprint on 12 and 13 November 2022. Additional cleaning audits are scheduled.

Lead: Head of Facilities **Timescale: Complete**

Changes have been made to the housekeeping rota to ensure consistency across the department.

Lead: Head of Facilities **Timescale: Complete**

All equipment being kept in corridors and all damaged equipment has been removed by the Environment Waste Team and disposed of. Replacement chairs and furniture has been ordered and temporary seating has been put in place where required.

Lead: Head of Midwifery **Timescale: Complete**

Monthly hygiene audits will be undertaken presented at the monthly Quality and safety meeting

Lead: Director of Nursing for Children and Women clinical board

Timescale: Complete

Audits are undertaken by the IP&C team on a monthly basis and the Clinical Board Director of Nursing is also undertaking walk arounds and Tendable audits on a regular basis

Lead: Director of Nursing for Children and Women clinical board

Timescale: Complete

A programme of Tendable core standard audits are currently being tailored for Senior Midwife Team.

Lead: Corporate Nursing **Timescale: January 2023**

The recent procurement of the Tenable digital audit platform will support greater oversight of regular IP&C audits by the senior management team. Ward cleaning scores to be added into Tenable (appendix 24).

Lead: Senior Midwifery Team **Timescale: Complete**

<u>Equipment</u>

Basic checks were not conducted on essential equipment including resuscitation equipment.

<u>Improvement needed</u>

The health board is required to provide HIW with details of how it will ensure that all equipment is safe to use and checked on a regular basis.

The checking, cleaning and restocking of essential maternity equipment, particularly the resuscitaire have been strengthened in response to HIW findings. Following the HIW inspection the checklists have been reviewed and streamlined. The existing and

new checklists are included in appendix 25. A recent audit of daily checking compliance has been undertaken showing significant improvement. These results are also within appendix 25.

It is the responsibility of every midwife to check the equipment in the rooms that they are using on a daily basis or after each use. Where rooms are unused for a full day a midwife will be allocated to undertake these checks.

Compliance with the resuscitaire checklists will be monitored by the Senior Midwife or Head of Midwife and this will be undertaken through the Tendable audit platform.

Lead: head of Midwifery **Timescale: Ongoing**

Leadership and Governance

Findings We were not assured that the leadership and governance arrangements at both local and board level ensured the safe oversight and management of safety in the maternity service. This included an apparent disconnect between divisional leadership and frontline staff:

There were significant backlogs in managing and addressing incidents. This meant that learning was not undertaken in a timely and effective way to reduce the risk of reoccurrence.

Serious incident investigations had extended timescales for investigation and the initial reviews did not always pick up important issues for immediate learning. This was evident in one recent incident where a neonate sadly died.

Immediate actions put in place as a result of serious incidents were not always put in place and managed effectively. An example of this was as a result of a recent incident resulting in a catastrophic harm, curtains on the IOL should not be closed around women who were not being monitored. During our inspection we saw that curtains were routinely closed, and women not checked on at sufficient intervals to prevent a reoccurrence.

Staff from different healthcare professions informed us that staffing levels for midwives, medics and ancillary staff regularly fell far below expected and safe levels. Although this had been acknowledged by the health board, the associated level of risk this has caused had not been mitigated sufficiently. This placed women and babies are an increased risk of avoidable harm. Examples noted include:

We observed and heard of significantly low levels of staffing in both midwifery and medical teams.

The units frequently did not have sufficient staff to maintain basic safety standards. We were advised that across the units the establishment of 24 midwives was frequently not met and at times dropped to 17, which was 70% of the required level.

BirthRate plus was in place for establishing staffing levels. However, we were advised that this was frequently not met due to insufficient and inadequate skill mix. We were provided with examples whereby junior staff were placed in complex situations for which they had not received training and were not sufficiently experienced to deal with. We were made aware that the postnatal area was at times staffed by one midwife instead of three. This area also sometimes included antenatal women.

Band 5 staff were being included in the numbers despite being on supervisory preceptorships.

We were made aware that the postnatal area was at times staffed by one midwife instead of three. This area also sometimes included antenatal women.

Medical staff advised that they frequently had to act into different medical roles i.e., seniors into junior on the on-call rota due to severe staffing issues. This included three vacant training posts due to maternity leave which were unfilled.

There was evidence provided to show that low staffing levels had contributed to patient safety incidents. These included an incident whereby the wrong blood was transfused to the wrong patient.

We were made aware Midwives who have expertise in low-risk management were often being told to work in high-risk areas, ultimately placing the woman, babies, and themselves in increased risk. An example of this issue was community midwives working with women who required high dependency care.

Improvement needed

The health board is required to provide HIW with details of how it will ensure that there are effective ward to board governance processes and systems to ensure risks are identified and mitigated.

The health board is required to provide HIW with details of how it will ensure that incidents and associated learning are recorded, investigated and shared in a timely manner.

In response to the Ockenden report a RAG rated assurance report has been produced benchmarking against the 89 immediate actions. A maternity Oversight Group has been established and is chaired by the Executive Director of Nursing for Cardiff and Vale University Health Board, to review the progress against these recommendations. This is attended by, additional members of the executive team. The Ockenden assurance report is contained within appendix 26 and 27 and examples of the Executive Led Maternity and Neonatal Oversight Group agendas are included in appendix 28

Lead: Exec Director of Nursing **Timescale: Ongoing**

Due to long term sickness and maternity leave the Maternity and Obstetrics Directorate are 1 tier of medical trainees short. The risk this has posed has been mitigated by increasing locum rates on all tiers, making use from external locum agencies and where possible increasing our academic, research and fertility trainees on call commitments. Occasionally consultants have to act down to fill gaps as per the Welsh contract. The Health Board have also entered discussions with HEIW to ensure trainee allocation is fair across all health boards. Five non-training junior doctor posts have been advertised and will be appointed to at the expense of the Health Board. At present three posts have been appointed to, all three are international doctors (there were no UK based applicants). There is a significant delay from appointment to these doctors taking up their post due to immigration arrangements. Once in post they also need to be supported and assessed before they can contribute to our on-call rotas. We are open to any suggestions on how we can improve this situation further.

Lead: Clinical Board Director **Timescale: Ongoing**

Both the Quality Safety and Experience Committee and The Board have received a full verbal briefing on the maternity position and the immediate findings of the improvement plan have been shared in both private sessions which is normal practice until HIW reports are published in the public domain. Following publication, the report and full improvement plan will be reported to Public QSE and progress will be monitored through the committee.

Tendable has been implemented in Maternity since November 2022 and since that date 24 audits have been undertaken to provide oversite of Infection prevention and control standards and core standards. There is Executive oversight of all Tendable audits.

All patient safety investigations now have a designated Responsible Officer and are on track to be completed within the specified time frame. Patient safety investigation meetings are held monthly to review all Nationally reportable Incidents (NRI). These are shared at Clinical board Quality and Safety and the Quality and Safety audit sessions to monitor progress with

Investigations and associated improvement plans and to manage constraints. Progress and constraint are discussed monthly at Clinical Board / Executive reviews.

There are eight NRI under investigation within Maternity Services. Three have been completed since the inspection. Of the NRIs that remain open, 4 investigations have extended past the intended completion date and are overdue for reporting to the Delivery Unit. Three of these investigations are nearing completion and are expected to be reported to the Delivery Unit in January 2023 and the fourth is being undertaken by external investigators and it is anticipated that this will be complete in the near future.

There are sixteen patient safety incidents that are recorded as being having not been reviewed within 30 days, at the time of the inspection this number exceeded 200. The Clinical Board Director of Nursing and the Risk and Governance Lead read and review all incidents following reporting in addition to the oversight and management by the clinical team.

To support with the backlog of datix cases and to ensure incidents are reviewed in a timely manner and learning from events takes place the Governance Team has been increased to include a band 6 Datix Midwife and a band 6 delivery suite Deputy Ward Sister. Weekly datix meetings are held to review all incidents and identify cases that need further review at the Directorate bi-weekly clinical risk MDT meeting.

New health board job planning guidelines suggest half a session per week allocated in job plans have been implemented to increase Obstetric capacity to support Patient safety investigations. Obstetric job plans have been reviewed to include these sessions. 3 sessions for Obstetrics and 1 session of neonatal services are now in place.

Lead: Director of Nursing for Children and Women clinical board

Timescale: Ongoing

Cascade trainers have been identified and trained in blood transfusion competencies. All staff to be trained by 30th December 2022

Lead: Practice Development Midwife **Timescale: Ongoing**

The health board is required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every shift within the maternity service.

The midwifery establishment based on the 2019 BirthRate+ assessment is 244 Whole Time Equivalent (WTE) frontline staff band 5-7. During the July, August and September the department held 24 wte vacancies and also had increased short-term sickness related to covid-19. To mitigate these staffing pressures non-clinical midwifery roles were redeployed to work in the clinical areas.

In October 2022 26.4wte newly qualified midwives joined the UHB. These midwives had an induction of 4 weeks and an example of their induction is included in appendix 29. From the 24th October 2022 the newly members of staff became part of the midwifery numbers available to be rostered for frontline shifts. The midwifery establishment is currently 246.4wte, an over establishment of 2.46 wte midwives. There are currently 10 wte midwives on maternity leave with a further 8wte scheduled to commence their maternity leave in 2023.

To ensure safe staffing levels it has been agreed that the Directorate should continue ongoing recruitment efforts and to appoint beyond the agreed establishments to provide resilience in the workforce and to mitigate the effects of significant maternity leave. Consideration is being given to overseas recruitment of midwives as present. Appendix 30 contains the midwifery recruitment data.

Lead: Head of Midwifery **Timescale: Ongoing**

To support the clinical areas during periods of low staffing or high acuity an escalation rota has been implemented for the non-clinical midwives, the December rota can be found in appendix 30.

Lead: Head of Midwifery **Timescale: Ongoing**

There have been a number of conversations with HEIW to explore the opportunities for larger intakes and two cohorts each year to ease recruitment challenges, this requires support from Welsh Government.

To mitigate for low midwifery staffing the Homebirth Services have been suspended and the Midwifery Led Unit was closed for a period of time. In addition, community services were centralised and enhanced overtime was offered to staff and experienced band 6 midwives were redeployed to support in areas where women with complex needs required care. As a consequence, staff

that would usually be working in low risk areas such as community services were asked to work within labour ward. There is continuous risk assessment of acuity of maternity services to inform these decisions with oversight by the Board.

All midwives are appropriately trained and qualified to work in all areas of the maternity unit. Midwives have base for a fixed period however all are employed on a rotational contract. Midwives have a preferred place of work and in order to prevent rotation may suggest they are not competent to work in a particular clinical area. Discussions are ongoing to develop an annual work plan for all midwives to rotate through each clinical area in a 12-month period.

The current workforce and skill mix is under review the Health Board is contributing to national work to understand the role of Band 4 Assistant Practitioners and is dependent on the national directive

Lead: Head of Midwifery **Timescale: Ongoing**

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

Service representative: **Suzanne Rankin**

Name (print):

Job role: **Chief Executive**

Date: received via Objective Connect 23 December 2022

Appendix C - Immediate improvement plan (March 2023)

Service: University Hospital of Wales - Maternity Unit

Date of inspection: 27, 28 and 29 March 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The health board is required to provide HIW with details of the action taken to: safely secure medicines used on maternity unit to help prevent unauthorised access demonstrate medicines are being stored at an appropriate temperature according to the manufacturer's instructions	Standard 2.6 Medicines Management	TDSI access has been activated by estates/security to prevent unauthorised access to the T2 anaesthetics room where the emergency haemorrhage drugs are stored in the fridge. Registration of all Band 7's onto the Tendable system and to perform weekly audits in every area of maternity unit (audits include fridge temperatures), discussed at Band 7 meeting 4th April 23. Senior team to have oversight of completed audits. A maternity Tendable audit has been developed which includes medicines safety and other core standards. All inpatient operational band 7 midwives have now been registered on Tendable. To further strengthen this action the band 7 delivery suite	Security Senior Midwifery Management Team	Completed completed

demonstrate Controlled Drugs are subject to regular checks.		coordinators have also been asked to register on Tendable and this will be complete by 8th May 2023. Band 7 managers and Delivery Suite shift co-ordinators reminded of their responsibility for the medicines safety checks seven days a week. Monthly 1:1 meetings will be held by Senior Midwifery Managers with Operational Band 7 midwives to discuss ongoing compliance and improvement actions	Operational Lead Midwives for all areas and Senior Midwifery Management Team	30th April 2023 – following a full month to reflect on compliance

Findings

Security -

On 27, 28 and 29 March 2023, HIW identified medicines were not securely stored throughout the maternity unit.

Medicines were stored in both cupboards and a fridge in the unlocked anaesthetic room in T2, where key swipe access was not in operation

The medicine fridge in postnatal ward clean utility room did not have a functioning lock and the door to the utility room, whist the door was keypad coded, it was latched open throughout the inspection

Adrenaline was not securely stored in the Midwife Led Unit, although the box was subsequently sealed by staff during the inspection.

The health board's Medicines Code provided to HIW refers to medicines being stored securely; it describes cupboards and fridges needing to be locked when not actively being used.

HIW is not assured medicines stored on the Maternity unit, which should be stored in a lockable cupboard or a lockable fridge are being suitably stored to reduce the risk of unauthorised access. This poses a potential risk to the safety and wellbeing of patients and other individuals who may access and ingest medication not meant for them.

Storage -

On 27 March 2023, HIW identified daily checks of the fridge temperature had not always been recorded for fridges across the Maternity unit. For example, for "North Fridge" we saw 4 gaps in records for February 2023, for labour ward fridge there were 9 gaps in February and 9 gaps

in March 2023. Scanned records of fridge temperature recordings for January, February and March 2023 indicated that the trend for not recording fridge temperatures daily had not improved to March 2023.

The Medicines Code provided to HIW refers to medicines refrigerators. The code states (6.1.6) that medicines refrigerators must have the temperature monitored and recorded daily.

HIW is not assured ongoing monitoring of the temperatures of the medication fridges on the maternity unit is being conducted to check and demonstrate medicines are being stored at an appropriate temperature according to the manufacturer’s instructions. This poses a potential risk to the safety and wellbeing of patients who may receive medication that has not be stored appropriately and so may not be as effective when used for treatment.

Controlled Drugs –

On 27 March 2023, HIW saw Controlled Drugs were being stored securely. However, we identified daily stock checks of the Controlled Drugs on the Delivery Suite had not always been recorded. We saw 8 gaps in the records for March 2023. The health board’s Medicines Code provided to HIW described stock balances of all Controlled Drugs must be reconciled a minimum of once daily and a record of the check recorded.

HIW is not assured checks of Controlled Drugs on the maternity unit are being conducted daily in accordance with the health board’s Medication Code and to promote the safe and effective management of these drugs in line with regulatory requirements.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to safely use sharps bins	Standard 2.4 Infection Prevention and Control and Decontamination	A review of all sharps bin currently in use has been undertaken to ensure compliance with the required standard	Senior midwifery Management Team	Completed
		UHB Medicines Code has now been published on WISDOM (Guideline resource) and staff SharePoint page.	Consultant Midwife & Digital Midwife	Completed

		Sharps boxes expiry information has been shared via the safety briefings in all areas of the maternity unit. Checking of Sharps boxes is to be included in Tendable audits.	Operational lead midwives for all areas	Completed

Findings

Waste –

On 27, 28 March 2023, HIW saw undated and over full sharps bins throughout the maternity unit. In the midwife led unit we shaw a full sharps bin dated 28 October 2021. This bin was removed on 29 March 2023 and other sharps bins were subsequently appropriately dated and removed if full.

The Sharps Management Procedure provided to HIW described the safe labelling, storage and replacement of sharps containers.

HIW were not assured sharps bins within the maternity unit are being effectively and safely managed in line with the health board procedure. We were not assured that the associated risk of cross infection and injury to patients and visitors to the ward has been mitigated as far as possible.

The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to promote effective infection prevention and control and decontamination.	Standard 2.4 Infection Prevention and Control and Decontamination	Band 7 managers have been reminded of their responsibility for IP&C audits and checks. Monthly 1:1 meetings will be held by Senior Midwifery Managers with Operational Band 7 midwives to discuss ongoing compliance and improvement actions. Registration of all Band 7's onto the Tendable system.	Senior Midwifery Management Team	Complete Completed

		A maternity Tendable audit has been developed which includes IP&C and other core standards. All inpatient operational band 7 midwives have now been registered on Tendable. To further strengthen this action the band 7 delivery suite coordinators have also been asked to register on Tendable and this will be complete by 8th May 2023.	Senior Midwifery Management Team	Completed
		Communication will be disseminated via safety briefing, email and included in group supervision to remind all staff of their responsibility when both leaving a room and entering a room on Delivery Suite to ensure that the cleaning is of a high standard. Weekly spot checks for cleanliness to be undertaken. An email was sent to all staff on 4th April	Band 7 manager for Delivery Suite, Band 7 co-ordinators, and Clinical Supervisors for Midwives team with oversight by the senior management team	Completed
		IP&C checks are to be included within Tendable audits.	Band 7 operational leads	Completed

		Discussed with the university to ensure that core standards and values including IP&C and decontaminations should be included in training to ensure this is recognised as a priority amongst newly qualitied midwives. Cleaning and checking have been added to the preceptorship induction programme and SSSA training.	Senior Midwifery Manager for outpatient services, PEF and PDM midwives	

Findings

During our inspection we inspected the environment of the Maternity Unit. HIW is not assured effective processes were in place or being followed to prevent healthcare acquired infections.

On 29 March 2023 in 3 unoccupied delivery rooms on the delivery ward, we observed blood and visible dirt on computer keyboards, unclean commodes, dirty baby resuscitaires, blood and dirt on the floor as well as dirt on the drawers.

Dated labels were not routinely used throughout the maternity unit to show when equipment had been cleaned and decontaminated.

On 27 March 2023, the cleaning schedule on Induction of Labour Ward was dated November 2022 and no checklist for March 2023 could be found.

The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to ensure that all equipment is safe to use and checked on a regular basis	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	A stocking and medical equipment role has recently been appointed to and this individual will be tasked with oversight of all medical equipment to ensure maintenance, servicing and decontamination standards are met. All Band 7 operational managers and deputy ward managers and Band 7 delivery suite co-ordinators are to	Senior Midwifery Management team Senior Managers for In and Outpatient services	Completed Completed

		register on Tendable to allow them to undertake medical equipment audits. A maternity Tendable audit has been developed which includes equipment checking and other core standards All inpatient operational band 7 midwives have now been registered on Tendable. To further strengthen this action the band 7 delivery suite coordinators have also been asked to register on Tendable and this will be complete by 8th May 2023. Meeting to remind to Band 7 managers of their responsibility for ensuring that the checking of equipment is undertaken. In charge band 6 midwife in each area to be allocated on every shift will be accountable for all daily checks.	Senior Managers for In and Outpatient services	Completed
		Meeting with Operating department Practitioner leads to agree defibrillator checking process on T2. HIW findings have been shared with Operation Department Practitioner manager in main theatres for wider dissemination.	Lead midwife for T2	Completed

Findings

On 27 March 2023, HIW identified daily checks of essential maternity equipment, including resuscitaires and defibrillators had not always been recorded daily across the Maternity unit. The check list in T2 for March 2023 showed that daily checking was inconsistent for the

defibrillator. The emergency equipment daily checklist for March on the Post Natal ward, viewed on 27 March 2023 was not completed for 8, 9, 10,18,21 and 22 March 2023. HIW is not assured that daily checks were being conducted to identify equipment faults for equipment that may be required in the event of an emergency.

The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to ensure patient safety and the swift, safe transfer of patients between areas of the Maternity unit in the event of a medical emergency.	Standard 3.1 Safe and Clinically Effective Care	A daily lift report is sent to the Directorate Management team regarding status of maternity lifts. A standard operating procedure (SOP) is being developed to ensure a standardised response in the event of lift failures in maternity services. The SOP will support the transfer of all women undergoing Induction of labour to T2 for ongoing care. All women in the Midwifery Led Unit (MLU) whose care is subject to consideration of escalation will be transferred to T2 and discussion will be undertaken with all women on MLU to explain the implications of the lift failures and to agree their location of care. The SOP will specify alternate routes and requirements to accompanying women. The above draft SOP has been sent to all midwifery and medical staff 18th April 23. It will be ratified in our local Maternity Professional Forum on the 10/05/2023	Senior Leadership Team and Head of Estates Consultant Midwife for MLU and Senior Midwife for Inpatient area	Completed Complete Completed

		To discuss possibility of an override function with lift manufacturers. Maternity have been provided with a ‘hold off key’ for lift 9 so that in cases of only 1 functioning lift we have control of the lift to allow us sole control in order to ensure safe and timely transfer of women if required.	IOL lead midwife and Senior Midwife for Inpatient area	Complete
		To ensure the swift, and most timely transfer of patients from the Ground floor (MLU) to Delivery Suite, a clear walked route through the hospital has been identified and all staff are aware of this. In the event of all lifts malfunctioning an individual risk assessment for all MLU women (and care options) will be undertaken at the time as per maternity lift SOP.	Consultant Midwife, Operational Lead midwife for MLU and Senior Midwifery Manager for Outpatient services	Completed
		Lifts have been included on the Directorate Risk Register have been escalated to the clinical Board and Executive Team. Executive team to be given daily update by maternity unit manager.	Senior Leadership Team	

Findings

Lift

27 – 29 March 2023 HIW noted that 3 of the 4 lifts for the maternity unit were out of order. This meant that patients needing emergency transfer to the delivery unit or theatre (floor 2) from other areas of the maternity unit risked delays and lift malfunction of the only remaining functioning lift. An alternative route was described as possible for emergency situations; however, this was a longer route and would take women through public areas of the hospital. HIW are not assured that timely plans are in place to protect the safety and dignity of women and babies in the event of all lifts malfunctioning in the unit.

The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to provide assurance that documentation is stored in line with GDPR	UK General Data Protection regulations	Elective Caesarean section lists will continue to be printed but are now kept in a folder within the lockable patient notes trolley on T2, making them inaccessible to patients and visitors.	Operational Lead Midwife for T2	Completed
		Information Governance E-learning compliance to be improved to 100%.	Operational Lead Midwives for all areas	End of April 2023
		All staff have been reminded of their responsibility to securely store medical notes.	Operational Lead Midwives for all areas and Senior Management team	Completed

Findings

Patient records

On 28 March 2023 in T2 on an accessible desk, we saw a full theatre list with detailed personal information for patients due for caesarean section. On 28 March 2023 we saw a computer screen on a ward desk with detailed personal information of all patients on the ward, visible to passing visitors. On 27 March 2023 we saw (unaccompanied) patient notes left on a windowsill and patient notes left on an unstaffed desk.

On the 29 March 2023 in the unlocked clean utility of the transitional ward, we saw a full list of patients on the ward, detailing personal information including full names, reason for admission, including medical history of both mother and baby. Whilst this room was "staff only" the door was wedged open and accessible to passing visitors/patients.

HIW are not assured confidential patient information is used and stored in line with GDPR.

The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to safely store cleaning fluids	Standard 3.1 Safe and effective care	Estates request submitted for locks to be fitted to cupboard doors in dirty utility rooms on Delivery Suite, once completed cleaning fluids will be stored securely.	Senior Manager for Inpatient Services	End April 2023

Findings

Cleaning fluids

On 27, 28 and 29 March 2023 we saw that there were cleaning fluids stored in the unlocked dirty utility room on Delivery unit. This room door did not have a lock and there were cleaning fluids that we accessible to anyone that entered.

HIW is not assured harmful cleaning fluids stored on the Maternity unit, which should be stored in a lockable cupboard or room are being suitably stored to reduce the risk of unauthorised access. This poses a potential risk to the safety and wellbeing of patients and other individuals who may access cleaning fluids.

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): **Andy Jones**

Job role: **Clinical Board Director of Nursing**

Date: **06 April 2023**

Appendix D - Improvement plan

Service: Maternity Unit, University Hospital of Wales, Cardiff and Vale University Health Board

Date of inspections: 8, 9 and 10 November 2022 and 27, 28 and 29 March 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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to update direction signage to all maternity wards from all entrances to the hospital	Standard 2.1 Managing Risk and Promoting Health and Safety	The newly reformed service user group MNPV (Maternity and Neonatal Parents Voices) will be asked to walk through the hospital site to maternity to highlight any areas where signage and access can be improved. Any signage updates will be bilingual to include both English and Welsh.	Senior Midwifery Leadership team & estates staff	September 2023
The health board is required to review and update the induction of labour ward environment to ensure that patient privacy and dignity are protected	Standard 2.1 Managing Risk and Promoting Health and Safety	The induction of labour ward is a nine bedded area that is incorporated within the footprint of the ante-natal ward. Two side rooms have been created by utilising office space to ensure	Senior Midwifery Manager for In-patient services	Complete

		that women in the early stages of labour can receive one to one care in a private and dignified environment.		
The health board should ensure procedures are in place to ensure that mixed cohorts of patients are only used as a last resort	Standard 2.1 Managing Risk and Promoting Health and Safety	Since the last inspection, two single rooms have been made available for Antenatal inpatients on the Antenatal ward through moving offices to other parts of the unit. Thus, minimising the risk of having a mixed cohort of patients. If mixing of patients is necessary, an individual needs-based risk assessment will be completed, and staffing adjusted accordingly.	Senior Midwifery Manager for In-patient services and Head of Midwifery	Complete
The health board should ensure that all relevant risk assessments for pressure and tissue damage are completed when clinically indicated.	Standard 2.1 Managing Risk and Promoting Health and Safety	A standard operating procedure (SOP) has been developed to ensure that maternity patients are risk assessed for pressure and tissue damage using the Purpose-T risk assessment tool. Individual care plans for maternity have been developed in conjunction with Tissue Viability services to deliver high quality care. Included in the	Senior Midwifery Manager for In-patient services	Actions complete with ongoing implementation

		SOP are bespoke public health posters to educate families on preventing pressure damage during their stay in maternity. The SOP will be published in June 2023 alongside a comprehensive training programme for staff.		
The health board should ensure that women with mental health problems are routinely asked about their mental health throughout their care	Standard 2.1 Managing Risk and Promoting Health and Safety	When women and pregnant people present, the named community midwife will complete a booking consultation. As part of this consultation a booking risk assessment and referral section is completed in the All Wales Antenatal record, this aims to identify any significant mental health risk factors including serious mental health issues requiring referrals to the perinatal mental health team and specialist obstetrician. There is an additional section which screens for the mild to moderate mental health issues. It prompts the midwife to ask the 'Whooley' questions which is a validated tool for screening for antenatal and Postnatal mental health. These two questions are then adapted to form a 'safer lives question' have you over the last 2	Consultant Midwife for Public Health, ELAN midwives and Senior Midwifery Manager for Outpatient services	End of 2023

		weeks felt unable to stop or control worrying' which is asked at every Antenatal consultation. Any positive disclosures will be referred to either the perinatal mental health team or emotional health needs midwife for further support. These responses are included within documentation audits. If a woman presents with significant mental health issues at any stage in her pregnancy, then a complex care plan will be developed with the specialised midwife for perinatal mental health, perinatal mental health team and obstetrician in early pregnancy. This will then be adapted by 36 weeks gestation to ensure that the appropriate care is provided during the antenatal period, birth and the postpartum period. All mild to moderate cases will be supported by the emotional health needs midwife and psychologist within the perinatal mental health team. Furthermore, for women attending the Women's wellbeing clinic which supports survivors of harmful practices and women seeking sanctuary there is a dedicated psychologist available to		

		provide support in preparation for birth and the postpartum period. All maternity staff attend mandatory study days, where awareness is raised around the importance of Antenatal and postnatal screening for mental health issues and what further support services are available for women and their families. These study days are facilitated by the specialist midwives and perinatal mental health team. Funding has been secured to recruit a full time psychologist to support women with birth trauma, tokophobia or following loss. The psychologist will be linked with the emotional health midwife and direct referrals can be made from the named community midwife when disclosures are made through the screening at every appointment. This recruitment is to be fulfilled before the end of the year.		

Review and update the capacity of ELAN and Women Seeking Sanctuary services taking into consideration additional workload related to training	Standard 7.1 Workforce	Caseloads are regularly reviewed, and junior members of the ELAN team are being supported to upskill in the more specialised areas (e.g., Women seeking sanctuary) for the purposes of succession planning and to ensure appropriate case loading numbers. Mandatory study days have recommenced, including training from specialised midwives to upskill the wider workforce. There is also a dedicated psychologist for Women's wellbeing clinic which will support the specialist midwife for women seeking sanctuary and survivors of harmful practices to be available for cascade training to upskill staff. Collaboration with third sector agencies such as Bawso and Oasis further provide support for this specialist service so that this service is not over capacity. Plans to recruit a Healthcare Support Worker for ELAN support is ongoing.	Consultant Midwife for Public Health and Senior Manager for Outpatient Services	Ongoing

The health board must review 24 hour maternity theatre staffing in line with other specialities and ensure consistent staffing levels to ensure patient safety.	Standard 7.1 Workforce	A business case is being developed for a staffing model for maternity theatres which would bring the obstetric staffing in line with UK standards for intra-operative anaesthesia, the Association of Perioperative Practice, British Association of Perinatal Medicine and local IP&C standards. This business case is currently in draft form, but once finalised, will be submitted to the clinical board for consideration.	Senior Midwifery Manager for in-patient services	End of 2023
The health board should work with social services to ensure that 24 hour supervision is provided by social services staff and will not require staff from the maternity unit to deliver 24 hour supervision.	Standard 7.1 Workforce	All vulnerable women or those with complex social needs have a comprehensive birth plan agreed between health and social services early in their pregnancy which ensures 24 hours supervisions during the post-natal period. In the event of an unexpected admission eg a concealed pregnancy or admission of an out of area woman, the situation is escalated to Emergency Social Services Duty Team to provide out	Consultant Midwife for Public Health and Vulnerable families	Complete

		of hours supervision as quickly as possible. If in any circumstance the baby cannot be placed within an acceptable timeframe then this will be escalated to the executive and safeguarding teams via the multiagency support hub. All essential safeguarding contact numbers are available in every clinical area.		
Guidance for birthing partners should be effectively communicated during the antenatal period	Standard 1.1 Health Promotion Protection and Improvement	The Health Board website has been updated to reflect current and amended guidance. Antenatal Education sessions includes this information. Community & clinic midwives discuss during antenatal appointments & pre- clerking for elective caesarean sections.	Senior Midwifery Manager for Outpatient Services	Complete

The health board must ensure that regular minuted team meetings take place and are meaning, supportive and a valuable	Standard 7.1 Workforce	A list of all regular meetings throughout the monthly calendar has been produced, with a file created within the shared drive to save all minutes into.	Senior Leadership Team	Complete
The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels	Standard 7.1 Workforce	Workforce vacancies are regularly reviewed. Streamlining process is almost finished for 23/24, with all band 5 midwifery vacancies being filled (4 nurses have been recruited through streamlining for 2023/2024). Retention work includes: Ongoing Work with Clinical Supervisor for Midwives and the management team to support staff in work, ensure work life balance requests are considered/fulfilled. Greatix nominations, service user feedback and positive practice feedback is given to individual staff regularly. Development programmes for HDU care, labour ward co-ordinator and Band 4 roles are being explored. Three recruitment events for the UHB have been attended in the last 6	Senior Leadership and Operational Teams	October 2023

		weeks by representatives from maternity, and further events are planned over the Summer. New consultant posts have been funded and are being recruited to in the current months. There are rotational plans in place for speciality trained doctors to ensure a full compliment of medical staff.	Clinical Director Clinical Director	August 2023 September 2023
The health board is required to review and strengthen the induction process for newly qualified midwives	Standard 7.1 Workforce	Feedback has been received from the 22/23 cohort of newly qualified midwives, and this has aided the development, updating and flow of the 23/24 induction and preceptorship programme. All streamlining recruits will receive a welcoming email from the Head of Midwifery prior to their start date, an assigned Clinical Supervisor for Midwives, a buddy band 6 midwife and welcome pack. Current practices of group supervision and regular drop-in sessions for support	Senior Midwifery Manager for Outpatient Services and Practice Development Midwife	Sept 2023 - Aug 2024

		will be ongoing. The role of a preceptor lead midwife is also being explored to support the programme.		
The health board must monitor all mandatory training rates and prioritise low compliance.	Standard 7.1 Workforce	A live training compliance database has been created to view training rates. A recent drive on mandatory training compliance has seen an improvement within Birth Rate+ staff from 74.1% (Oct 2022) to 83.78% (April 2023). Study weeks for staff have been implemented to provide allocated time to sustain overall compliance. There is a UHB wide target to support all mandatory compliance to be at 85% by June 2023.	Senior Leadership Team and Practice Development Midwife	Ongoing
The health board is required to ensure that staff are able to take adequate breaks during shifts	Standard 7.1 Workforce	The In-charge midwife within each area ensures that breaks are taken during the shift. If acuity is high, this is escalated to the senior managers, and non - clinical staff are then utilised for break relief. Staff have a canteen and 'staff	Operational managers with oversight of Senior Midwifery Managers	Complete

		haven' to use for breaks off the maternity unit if they wish to go.		
The health board must ensure that staffing escalation procedures are followed and communicated effectively.	Standard 7.1 Workforce	Escalation guideline and the Standard Operating Procedure has been updated and shared with all staff via both email and the staff SharePoint page so that all members of staff are aware of the process of escalation.	Senior Leadership Team	Complete
Review the effectiveness of the on-call rota for non-clinical midwives	Standard 7.1 Workforce	A fair and consistent approach is being adopted when non-clinical midwives are required to assist with acuity. Additional training needs, or a clinical refresh has been needed for some staff members. This is reviewed monthly.	Senior Midwifery managers	Ongoing
The health board is required to review and act upon themes and comments from staff in the HIW survey	Standard 7.1 Workforce	Staff and service user feedback is highly valued to aid improvement. Feedback sessions are to be facilitated by the senior leadership team around the publication date of the HIW report to discuss the findings, survey feedback, action	Senior Leadership Team	August 2023

		plan and give staff the opportunity to voice any concerns or ideas.		
The health board is required to gather feedback from students and act on this as necessary to improve student experience	Standard 7.1 Workforce	Fortnightly meetings are held between Head of Midwifery and Lead Midwife for Education at the local university. This provides the chance to share feedback or concerns in a timely manner. Senior management attend the regular Royal College of midwives caring for you student events throughout the year to listen, and share information with students of all 3-year groups.	Senior Leadership Team	Ongoing
The health board must ensure the appraisal process is evaluated and is meaningful to staff	Standard 7.1 Workforce	Recent drive on ensuring PADR rates are completed timely. (32% Nov 2022 - 67% April 2023), with a plan to further increase and sustain. Royal College of Midwives staff surveys will now include questions relating to both the benefits and meaningfulness of PADR/appraisal process for audit purposes.	Senior Midwifery Managers	Summer 2023

		Appraisals are compulsory for medical trainees and are led by HEIW by the Annual Review of Competency Progression process. Appraisal for all junior medical staff are facilitated through educational supervision. Educational supervisors are required to be trained in appraisal and feedback is provided by Junior doctors through the annual GMC survey.		
The health board must ensure that progression arrangements are evaluated and clearly communicated to staff	Standard 7.1 Workforce	All vacancy and progression opportunities are advertised via the Trac website. The links are also emailed to staff, and posted on the staff social media page to ensure awareness of progression opportunities.	Senior Midwifery Managers	Complete
The health board must risk assess birth partner use of scrubs / effective PPE with infection control and update practice to	Standard 2.4	Birth partners are able to wear their own clothes covered by disposable gowns and wearing masks and head cover as illustrated in the photographs attached. These	Senior Midwifery Manager for In-patient services &	Complete

ensure that the safety of patients is not compromised in theatres.	Infection Prevention and Control and Decontamination	arrangements are approved by Infection prevention and Control. Work has been carried out on CSSI (Complicated Skin and Skin Structure Infections) in association with WHAIP (Welsh Healthcare Associated Infection Programme) and our CSSI reports are available to view up until 2021. Bare below the elbow is adhered to and compliance is audited weekly via Tendable. Birth partners do not enter or go near to the sterile field, and therefore there is minimum risk of surgical field contamination. 	Procurement team	

The health board is required to feedback service user themes, comments and commendations to staff	Standard 6.3 Listening and Learning from Feedback	This is in place and ongoing via a multitude of platforms; Operational Band 7 meetings with use of safety briefings to further cascade. Themes and trends emailed to all staff every month, patient story and themes brought through Quality & Safety meetings and Maternity Professional Forums each month, with online attendance and minutes available to all staff.	Experience Midwife	Complete
The health board should consider how patient comments can be used to improve services	Standard 6.3 Listening and Learning from Feedback	A new chair has been appointed for the MNPV Maternity and Neonatal Parent Voices (MNPV), formally Maternity Services Liaison Committee (MSLC). This group is made up of members of the multi-disciplinary team and service users with the aim of two-way information sharing for feedback, education and support. In line with All Wales service user framework. The feedback through the 'Thank your midwife campaign' within Cardiff and Vale. As well as	Senior Leadership Team	Ongoing

		Greatix, Birth afterthoughts service, Risk & Governance meetings and the experience midwife is all shared either directly with individual members of staff, via safety briefings, or multi-disciplinary team meetings.		
The health board should consider necessary action from the less favourable themes and comments in our staff survey.	Standard 6.3 Listening and Learning from Feedback	The senior leadership team welcome all feedback for improvement. Visibility is recognised as an ongoing theme, daily walkarounds are prioritised by senior managers, walk with the Head of Midwifery has been implemented and staff voices initiative has been implemented and well received by staff. Engagement events are planned for the near future. Learning from events topics for the month have been set up to provide additional opportunities for staff to refresh and update their knowledge. Staff wellbeing is continuously on the UHB agenda for improvement.	Senior Leadership Team	Summer 2023

		The consultant team have recently had an away day, the purpose of which was to look at team working and what services should look like going forward. Future away days are being planned to further the discussion.		
The health board should ensure that appropriate pain relief is given in a timely manner	Standard 2.6 Medicines Management	Intentional medication rounds are commencing on antenatal and postnatal admission areas. During these rounds, midwives will be required to wear a tabard which indicates that they are carrying out a medication round and should not be disturbed. This will ensure that appropriate pain relief is given in a timely manner. There are dedicated obstetric anaesthetists present on delivery suite not covering other general areas in the hospital for prompt access to epidural/PCA medication. There is ongoing development of pre-printed stickers with analgesia options for Induction of labour ward to minimise delay in prescription of medication.	Senior Midwifery Manager for In-patient services	End of June 2023

The health board must ensure that a robust system for access, monitoring and tracking of essential medical equipment is in place	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	A recent appointment of a Band 3 'Environment co-ordinator' will ensure oversight of all equipment within the maternity unit. They will be responsible for the maintenance, replacement and ordering of all stock and equipment.	Operational Lead for environment co-ordinator	July 2023
The health board must implement a robust system to confirm appropriate checks are taken on fridge storage temperatures and actions completed as necessary	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	Fridge temperatures are now included in the weekly Tendable audits, carried out in each area of the maternity unit. Any actions that are identified as a result of the audits are accessible by the senior midwifery management team for oversight. Photographs of check sheets are included as part of the audit.	Operational lead for each area and Senior Midwifery Managers	Complete
The health board must conduct regular documentation audits and ensure that learning is shared	Standard 3.5 Record Keeping	The Clinical Supervisor for Midwives team conduct regular documentation audits and feedback to all staff grades through Praise Projects. Examples of how to complete documentation forms to a high standard are available within	Clinical Supervisors for Midwives Team	End of 2023

		the clinical area for any staff who are unsure. Student midwives complete an audit module as part of their curriculum in preparation for qualifying.		
The health board is required to review the process of reporting, investigation and management and communication of concerns and critical incidents	NHS Wales Health and Care Standards (2015) – Governance, leadership and accountability	All incident reporting is done via Datix system. Patient safety incident reviews are shared through Directorate Quality and Safety meetings. Communication and learning from events is cascaded via staff newsletters and topics of the month, with drop-in sessions for additional learning. A governance Share Point page is currently being developed to save past learning to archives for ease of access and staff updating. Communication and quality improvement work is ongoing via local MatNeo safety champion.	Senior Leadership Team	Ongoing
The health board must ensure full compliance rates with mandatory safeguarding training	NHS Wales Health and Care Standards (2015) – Governance,	The health board acknowledge that mandatory compliance has been below the level expected. Overall	Senior Leadership Team	Ongoing

	leadership and accountability	compliance is targeted to be 85% for all staff before the end of June 2023 (with the exception of staff members currently on maternity leave and long-term sick leave). Mandatory training study weeks have been introduced to ensure that this level (or higher) of compliance is sustained moving forward.		
The health board is required to ensure that risk and governance meeting actions and learning are shared with all staff	NHS Wales Health and Care Standards (2015) – Governance, leadership and accountability	All risk and governance meetings are conducted using a hybrid method of face to face and via Microsoft Teams. All meetings are also recorded, and minutes shared to all staff. The governance team are currently creating a Governance SharePoint page to publish their monthly newsletter to cascade learning, themes and use cases of interest to demonstrate examples of both good practice, and practice whereby learning has been identified. Band 8a Governance lead midwife will be going out to advert shortly.	Risk and Governance Team	End of 2023

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): Abi Holmes

Job role: Head of Midwifery