Experience, Quality and Safety Committee

Thu 04 February 2021, 10:00 - 13:00

Teams Meeting

Agenda

10:00 - 10:00
0 min

1. PRELIMINARY MATTERS

EQS_Agenda_04Feb2021.pdf (2 pages)

1.1. Welcome and Apologies

1.2. Declarations of Interest

1.3. Minutes of the Previous Meeting Held on 3 December 2020 for Approval

EQS_Item_1.3_Unconfirmed_Minutes_03-12-2020.pdf (15 pages)

1.4. Matters Arising from Previous Minutes

1.5. Committee Action Log

EQS_Item_1.5_EQS Action Log_04_February_2021.pdf (4 pages)

10:00 - 10:00
0 min

2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section.

10:00 - 10:00
0 min

3. ITEMS FOR DISCUSSION

3.1. Serious Incidents and concerns report

EQS_Item_3.1_ CONCERNS AND SI.pdf (10 pages)

3.2. Regulatory Inspections Report

EQS_Item_3.2 Regulatory Inspections Report DRAFT 04Feb2021.pdf (5 pages)
EQS_Item_3.2_APPENDIX 1 - 2020.12.18 Alun Jones HIW to Powys Teaching HB - HIW QI Bulletin Inspection pause.pdf (2 pages)
EQS_Item_3.2_APPENDIX 2 - HIW National Review of Maternity Services - FINAL.pdf (78 pages)
EQS_Item_3.2_APPENDIX 3 - HIW 19287 Powys Home from Home Birthing Centres - Final Published Translation Report.pdf (38 pages)
EQS_Item_3.2_APPENDIX 4 - HIW Tracker Report - Dashboard v2.pdf (1 pages)
EQS_Item_3.2_APPENDIX 5 - Notice of Decision CIW.pdf (2 pages)
EQS_Item_3.2_APPENDIX 6 - Haygarth Quality Check Summary 01.12.20 Published 29.12.20.pdf (11 pages)

3.3. Mortality Reporting

EQS_Item_3.3_Mortality Review Paper EQS.pdf (8 pages)

3.4. Safeguarding Update

EQS_Item_3.4_Safeguarding Update EQS.pdf (8 pages)

3.5. COVID-19 Incident Management Update Report

EQS_Item_3.5_IMT briefing paper.pdf (13 pages)

3.6. Maternity Services Priorities

EQS_Item_3.6_Ockenden Report of Maternity services.pdf (6 pages)

3.7. CAF Escalation Report & SaTH Update

To Follow

10:00 - 10:00
0 min

4. ITEMS FOR INFORMATION

There are no items for inclusion in this section.

10:00 - 10:00
0 min

5. OTHER MATTERS

5.1. Items to be brought to the attention of the Board and other Committees

5.1.1. Any other urgent business

5.1.2. Date of next meeting:

Thursday 4 February 2020, 10am.

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

04 FEBRUARY 2021,
10.00AM – 11.30PM
TO BE HELD VIRTUALLY VIA MICROSOFT TEAMS

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

AGENDA			
Item	**Title**	**Attached /Oral**	**Presenter**
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Apologies	Oral	Chair
1.2	Declarations of Interest	Oral	All
1.3	Minutes of the previous meeting held on 03 December 2020 (for approval)	Attached	Chair
1.4	Matters Arising from Previous Meetings	Oral	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR APPROVAL/RATIFICATION/DECISION**		
	There are no items for inclusion in this section		
3	**ITEMS FOR DISCUSSION**		
3.1	Serious Incidents and Concerns Report	Attached	Director of Nursing & Midwifery
3.2	Regulatory Inspections Report	Attached	Director of Nursing & Midwifery
3.3	Mortality Reporting	Attached	Medical Director
3.4	Safeguarding Update	Attached	Director of Nursing & Midwifery
3.5	COVID-19 Incident Management Report	Attached	Director of Public Health
3.6	Maternity Services Priorities	Attached	Director of Nursing & Midwifery
3.7	CAF Escalation Report & SaTH Update	Attached	Assistant Director of Commissioning Development
4	**ITEMS FOR INFORMATION**		
	There are no items for inclusion in this section		
5	**OTHER MATTERS**		
5.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
5.2	Any Other Urgent Business	Oral	Chair
5.3	Date of the Next Meeting: • 15 April 2020 via Microsoft Teams.		

Powys Teaching Health Board is committed to openness and transparency, and conducts as much of its business as possible in a session that members of the public are normally welcome to attend and observe.

However, in light of the current advice and guidance in relation to Coronavirus (COVID-19), the Board has agreed to run meetings virtually by electronic means as opposed to in a physical location, for the foreseeable future. This will unfortunately mean that members of the public will not be able attend in person. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

The Board is expediting plans to enable its meetings to be made available to the public via live streaming. In the meantime, should you wish to observe a virtual meeting of the board or its committees, please contact the Board Secretary in advance of the meeting in order that your request can be considered on an individual basis (please contact Rani Mallison, Board Secretary, rani.mallison2@wales.nhs.uk).

In addition, the Board will publish a summary of meetings held on the Health Board's website within ten days of the meeting to promote openness and transparency.

POWYS TEACHING HEALTH BOARD
EXPERIENCE, QUALITY & SAFETY COMMITTEE

UNCONFIRMED

MINUTES OF THE MEETING HELD ON THURSDAY 03 December 2020 VIA MICROSOFT TEAMS

Present:

Melanie Davies	Vice-Chair (Committee Chair)
Trish Buchan	Independent Member (Committee Vice-Chair)
Frances Gerrard	Independent Member
Susan Newport	Independent member

In Attendance:

Carol Shillabeer	Chief Executive
Alison Davies	Director of Nursing and Midwifery
Pete Hopgood	Director of Finance and IT
Claire Madsen	Director of Therapies and Health Sciences Director
Jamie Marchant	of Primary & Community Care and Mental Health Services
Wendy Morgan	Assistant Director of Quality and Safety
Julie Richards	Women and Children's Services Manager
Jeremy Tuck	Assistant Medical Director
Clare Lines	Assistant Director of Commissioning Development
Rani Mallison	Board Secretary
Rebecca Collier	Relationship Manager, Health Inspectorate Wales
Elaine Matthews	Audit Wales
Geoffrey Davies	Community Health Council

Apologies for absence:

Stuart Bourne	Director of Public Health
Frances Gerrard	Independent Member
Mark McIntyre	Deputy Director Workforce and OD

Committee Support:

Holly McLellan	Senior Administrator/Personal Assistant to Board Secretary
Shania Jones	Committee Secretary

EQS/20/79	**WELCOME AND APOLOGIES FOR ABSENCE** The Committee Chair welcomed Members and attendees to the meeting, and CONFIRMED there was a quorum present. Apologies for absence were NOTED as recorded above.
EQS/20/80	**DECLARATIONS OF INTERESTS** No interests were declared.
EQS/20/81	**MINUTES OF THE EXPERIENCE, QUALITY AND SAFETY COMMITTEE MEETING HELD ON:** **a) 01 October 2020** **b) 06 November 2020** The minutes of the previous meeting held on 01 October 2020 and 06 November 2020 were AGREED as being a true and accurate record subject to the following amendments to page 14 of those held on 01 October 2020: *Paragraph 3 of Mortality reporting to be replaced as follows:* *'The Committee Vice Chair queried if mortality reviews were being undertaken across the whole of the county or just in Brecon. In addition, the Committee Vice Chair asked would it be possible for the committee to have sight of the Extended Perinatal Mortality Data in addition to the Perinatal Mortality Data in future. The Medical director responded that the process was being taken one step at a time.'*
EQS/20/82	**MATTERS ARISING FROM PREVIOUS MEETINGS** No matters arising were declared.
EQS/20/83	**COMMITTEE ACTION LOG** The Committee received the action log and the following updates were provided. EQS/19/76 - It was proposed that an update on Research and Development be built into the Committee's workplan for 2020/21. EQS/19/22 - An update on this item would be provided to the Committee in February 2021.
ITEMS FOR APPROVAL/RATIFICATION/DECISION	

EQS/20/84	There were no items for inclusion in this section
ITEMS FOR DISCUSSION	
EQS/20/85	**Clinical Quality Framework Implementation Plan Update** The Director of Nursing and Midwifery presented the paper, outlining progress made on implementing the PTHB Clinical Quality Framework Implementation Plan, 2020-23. This was adversely affected due to the COVID-19 Pandemic resulting in activities scheduled for completion in year 1 deferred into year 2, along with the potential for a small number of year 2 priorities being deferred into year 3. The Director of Nursing and Midwifery advised that the PTHB Integrated Medium Term Plan 2020-2023 identified quality as a core component of the Health Boards strategic direction. The Clinical Quality Framework consisted of 5 goals and the progress related to each was led and coordinated by the corresponding Director. Attention was drawn to the table on page 4 outlining the elements of the Framework which had been progress, most of which were marked Amber; to Goal 1c (Patient Experience) marked as Red due to the delayed revision of the National Patient Experience Strategy (currently expected in 2021) and Goal 5 (Performance monitoring arrangements for clinical services) which had been delayed due the pandemic but would be expedited once conditions improved. *Mass vaccination had now commenced, at what point could business as usual be expected to return?* The Director of Nursing and Midwifery responded this was currently not known. However, once a critical mass of individuals in Powys and in Wales had been vaccinated, this would provide an understanding of the efficacy of the vaccine which would provide greater clarity for recommencing business as usual. It would then be necessary to consider what were the priorities for the local population. *A decision was made to step down the Patient Experience section of the framework. due to the current pressure the team was under with COVID-19 reporting. It was understood there was a possibility of an All Wales Protocol, which would be due to be published next year.* The Director of Nursing and Midwifery confirmed Chair had asked to be notified when the All Wales Protocol was

	published, or, if during the interim, Powys Teaching Health Board was in the position to pick the work back up. The Committee DISCUSSED the report and noted the requirement for revised timescales for some elements of the implementation of the Clinical Quality Framework.
EQS/20/86	**Serious Incidents and Concerns Report** The Director of Nursing and Midwifery presented the paper which provided a summary of patient experience and concerns, including complaints, patient safety incidents and claims for August, September and October 2020. The report also outlined serious incidents reported to Welsh Government and enquiries that have been received by the Health Board from Her Majesty's Coroner. The Health Board had achieved over 85% compliance in acknowledging formal concerns within two working days. The 30-day response rate was 51.5% which was an improvement however, still lower than the target. Incident reporting, referenced the reduction to numbers of incidents reported over the last year. The Ombudsman Report (Agenda item 3.3) was an internal review and was due mid-December. The Ombudsman's report and the internal review would inform recommendations for improvements for the complaints team. Learning and Improving from Concerns, Patient Experience and Incidents referenced the intention to develop a learning committee. Terms of reference were in preparation and an initial meeting planned for the new year. Incident reporting, referenced the reduction to numbers of incidents reported over the last year. The element to consider for serious incidents was the themes, trends, severity and early lessons to be learnt. Progress had been made to look at ways to manage serious incidents in a timely way. *Do the patients that are making a concern known to PTHB receive information about the impact that their raising of a concern had had?* If there had been an informal complaint or an open dialog then, the person identifying a concern would be aware fo the outcome. In addition, there was also a 'You Said, We Did' approach where it was published in clinical areas. Finally, when providing a formal response, it was acknowledged where there was learning needed, which was documented and confirmed.

	From August to October there were 19 serious incidents, was that unusually high? The Director of Nursing and Midwifery advised that this was not unusually high. This was partly down to COVID-19 related reports. Reporting of Serious Incidents was welcomed as it allowed for close monitoring for any themes, trends or concerns. *Of formal complaints only 50% get answered in the time frame. W what factors were causing the delays?* There were multiple factors to consider including process issues, system issues and service issues. It was important to consider capability and capacity, and was there a potential to stream line with the current processes in place? In terms of putting things right, sometimes there was opportunity to have a face to face conversation rather than go through the process e.g. written response, was important to provide a full service. *Is communication of learning across the Health Boards routinely checked? Or was that anticipated by the medical director's initiative?* Learning was shared across areas and other settings such as, local forums, sister forums and when senior staff came together to share information. Another example, would be the lesson learned meeting, which would be taken back to be shared within the hospital as well as the community. The Committee DISCUSSED the report and actions being taken to improve performance.
EQS/20/87	**Special Report issued by the Public Services Ombudsman for Wales** The Director of Nursing and Midwifery presented the report received by the Health Board under s28 of the Public Services Ombudsman (Wales) Act 2019 following a complaint made by Mrs A against Powys Teaching Health Board. The report provided details on the experience Mrs A had received. Mrs A originally complained to the Health Board in July 2019 about the care and treatment provided to her mother. Following that, Mrs A filed a complaint with the ombudsman in January 2020 due to the Health Board not progressing. After the initial interaction with the

	ombudsman two actions were put into place to resolve the complaint, which had not been completed. The Public Service Ombudsman made two recommendations, which included the provision of a further apology to Mrs A within two months of the final report. The Health Board's CEO personally responded to the Ombudsman. There was a review underway to investigate the complaints handling team which would focus on the ability and capacity to deal with complaints in an effective and timely manner. This review would consider whether additional training on the Putting Things Right (PTR) requirements should be undertaken. The Public Services Ombudsman for Wales would be informed of the outcome of the independent review. The recommendations of both reviews would inform the programme of improvement required, which would be supported by the Innovation and Improvement Team. *The Health Board was at fault and there were lessons that needed to be learnt. The response was acknowledged to be poor, and that learning would need to take place from the way this complaint had been handled. The Committee should be kept appraised of progress against the action plan.* The Director of Nursing and Midwifery explained that the Public Service Ombudsman had recognised that the complaints response can be complex, especially when the concern involved a number of providers and services. However, it was acknowledged that Powys Teaching Health Board did not do well and it was important to learn from it to make improvements going forward. IT was confirmed that this was an opportunity to learn and to change where possible. The reviews would be a defining factor that would help to focus on and improve services. *It was crucial that another complaint did not slip through.* The Director of Nursing and Midwifery confirmed that the aim was to not be in the position of letting anyone down and that Powys Teaching Health Board does its very best for people needing treatment. The Committee DISCUSSED and NOTED the report.
EQS/20/88	**Inspections and External Bodies Report, including Action Tracking**

	The Assistant Director of Quality and Safety presented paper which outlined the receipt and outcomes of regulatory inspections that had occurred during the reporting period and shared the HIW tracker and noted the change to completion dates for a small proportion of the actions. The Health Board had received 3, Tier 1 inspections which consisted of completion of self-assessment followed by a discussion between HIW and Ward Manager on the inspection date. Each of the reports have been positive, with a low number of improvements required. An overview of the current position relating to the implementation of recommendations following HIW inspections was provided and whilst there had been some delays in updating progress against recommendations, the tracker was contemporaneous. The quality check focussed on four key areas: Covid-19 arrangements, environment, infection prevention and control, and governance. Two visits reported no improvements and two have reported some improvements, in the areas of environment and governance. *In regards to the Tawe Ward report and the ligature risks, what direction would this take moving forward?* The next step was to await the outcome of that report but there currently was work surrounding this in regards to action plans. The Chief Executive explained that with regard to the ligature work, work had been undertaken and the proposal to the government had been approved. This was a substantial capital investment and works had been scheduled for implementation. There was over £1 Million of funding available. In terms of audit of CAMHS, multiple peer reviews had brought some good learning. It was a good way of working as there was no need to always rely on inspectorates, there was ability to gain fresh perspective on peer colleagues. *In respect of the Dashboard for implementation, items 17 and 18, both focus on Mental Health and Ward Services. Considering the up and coming inspection of Clywedog*

	Ward in Llandrindod, would it be appropriate to move forward the implementation of these items? The Assistant Director of Quality and Safety advised the action surrounding these in the report can be amended to add some context for future meetings. The Committee DISCUSSED the contents of the report and NOTED the revised deadlines for recommendations.
EQS/20/89	**Infection Prevention and Control Report** The Director of Nursing and Midwifery presented the paper which provided a summary of the work undertaken by the Infection, Prevention and Control (IP&C) team, within an existing action plan programme and in response to COVID-19. The focus of the team had been heavily on the current pandemic and the required new ways of working, s well as building on established ways of working to help support services. The approach going forward was outlined within the report, which included a refreshed approach to the delivery work programme, meeting structures and expansion of the IP&C team. Training and the up-take of training that was provided as a result as of the pandemic was outlined together with aseptic non-touch technique competencies and the progress made on bringing in training. Commissioning services were continually working with the providers to gain an oversight of the IP&C issues. Recent outbreaks had been managed and over seen by the Incident Management Team. *Was information offered on non-sarcoma infections? Was this information given to care homes in advance so they were sighted on this going forward? The incidents of infection numbers were remaining low, was that percentage based or on population numbers?* The Director of Nursing and Midwifery explained that the IPC incidents were recorded by per 100,000 population with Powys generally having a lower incident rate than the rest of Wales. This was reflected in the type of services provided. Current figures at the moment were a result of the preventative measures that were in place and it was expected that the measures taken in relation to COVID-19 would also have a positive effect on other diseases and infections.

	In relation to the offer to care homes, there was a focused approach on providing support. The work had developed over the last nine months and was outlined in the Winter Plan. There remains a challenge around COVID-19 outbreaks in Care Homes. In this case an Environmental Health Officer and a member of the Infection, Prevention and Control Team would visit that site to offer advice and guidance. *At the start of the pandemic assurance was given that agency nurses were not employed, in order to lessen the spread of COVID-19 between sites. Was that still the case? If agency nurses were coming from higher tier areas how would that affect Powys?* The Director of Nursing and Midwifery explained that PTHB were using agency nurses where they were needed but movement was minimised. Agency nursing had access to testing and all other measures to prevent the spread of COVID-19 in clinical settings and without the use of agency nurses it would not be possible to meet clinical needs. The Committee DISCUSSED and NOTED the paper.
	Maternity Services Assurance Framework The Director of Nursing and Midwifery presented the paper which provided an updated position in relation to the Maternity Assurance Framework. There continued to be a number of emerging reports and unfolding positions in relation to maternity services provided by commissioned services. Areas covered included: • Assurance work (maternity services within the overall assurance framework). • The implementation of the South Wales Programme and Aneurin Bevan University Health Board's (ABUHB) Clinical Futures Programme. • Cwm Taf Morgannwg University Health Board position. • Shrewsbury and Telford NHS Trust (SaTH). • Secretary of State investigation (at SaTH). • Wye Valley NHS Trust (WVT).

	• National Healthcare Inspectorate Wales (HIW) report for Maternity services due to be published on 19 November 2020. • Phase 2 Healthcare Inspectorate Wales (HIW) report for Maternity services. • 2020 Welsh Government Maternity Performance Board scheduled for Spring 2021. The Maternity Services Assurance Framework was used to help gain a better overall understanding of The Commissioning Services' performance in relation to the quality around maternity services. It aimed to accommodate qualitive data and intelligence to help make a full picture of the status of the services provided and commissioned. The HIW review of services reported that within Wales maternity services were delivered in a safe and effective way, with key areas for developments. The previous reports of phase one review for Powys, highlighted small immediate issues that were rectified straight away. Key areas to consider were availability of data sets and intelligence to inform the performance. Welsh Government Maternity Performance Board 2020 looked at the key enablers that allow data sets to reference the whole patient pathway for women and especially for women delivering outside Wales. A number of forums over the last six months have strengthened the quality governance framework within Women and Children's services. The Committee NOTED the paper.
EQS/20/91	**Commissioning Arrangements Update** The Assistant Director of Commissioning Development presented the paper which highlighted any providers in Special Measures or scored as Level 4 under the PTHB Commissioning Assurance Framework. It also provided an update in relation to Shrewsbury and Telford Hospitals NHS Trust. Betsi Cadwaladr had been taken out Special Measures on 24 November 2020. They had received £82 million for the next three and half years to help take forward Working Relations, Scheduled Care, Planned Care and Mental Health Services.

	SaTH had been placed under a Section 31 Notice, imposing further conditions on its regulated activity and an Improvement Alliance had been established with University Hospitals Birmingham NHS Foundations Trust (UHB). A new Chair and Director of Nursing had been appointed, both of whom had previously worked for UHB. An assessment framework had been put into place to meet the risks appropriately and the Quality improvement plan had been overhauled to allow for the development of a much more integrated system. *Is there weekly contact with them?* The Chief Executive explained that after speaking with the Medical Director of NHS England there was an optimistic outlook moving forward. The Chief Executive had an informal meeting scheduled in January with the Chief Executive of the UHB. There was a focus on key and critical issues although there were potential issues in delivering them. The estimated time frame was at least 18 months to 2 years before a stable improvement would be seen. In regards to Special Measures it was important that there was clarity on how an organisation could be removed from Special Measures. *Was feedback on patient experience from patients in SaTH being received?* The Assistant Director of Commissioning Development explained that patient experience was monitored, however, COVID-19 had made it difficult to access good quality patient experience information across a number of providers. In the last internal commissioning and assurance meeting this was the area where further work had been agreed. The SaTH patient experience questionnaire was on-going and waiting for the results to be analysed. Patient experience had been picked up in the commissioning framework. Activity across patient experience, particularly during COVID-19, was being shared at all Wales levels. The new system through the Once for Wales service would provide feedback from colleagues as well. The Committee DISCUSSED the paper.
EQS/20/92	**Clinical Audit Programme:** The Assistant Medical Director presented the Clinical Audit Programme.

	a) Update against the 2020/21 Clinical Audit Plan The key points presented to the committee were that one Audit cycle was finished with the learning to inform the next Audit cycle. This would allow for an evaluation of the performance and ways for improvements. The Paediatric Physiotherapy record keeping Audit, compared 2019 to 2020, which was seen as very positive. Attention was also drawn to additional areas which needed to be addressed. The learning component, allowed for the opportunity to make the appropriate plan to track progress and gave the ability to focus on such a plan during the subsequent Audits. *With respect to the audit of children on vacant caseloads, was this applicable across the wider settings?* The Chief Executive explained that one of the four drivers of learning was organisational and shared. The lessons that were applicable to everyone were shared. to allow for colleagues to see and understand how those lessons could affect practices in their own specialist areas. The Committee RECEIVED and APPROVED the report. **b) Progress against the Clinical Audit Improvement Plan** Only one action remains open (Appendix No. 17), which was to take the terms of reporting forward. This had been constrained due to COVID-19. As the process grows, the current reporting system would become easier and would allow for greater assurance of the activity and quality. *If there was an investigation of electronic monitoring for clinical auditing, would that system work for non-clinical Audit? It was important PTHB were not just introducing another system without ensuring its compatibility with current systems.* The Chief Executive confirmed the importance of using existing systems to their fullest extent before considering standalone systems. At present there was no plan to buy another system. *When strengthening the clinical approach to auditing and commission services, to what extent was it reasonable to think, that there would be an ability to respond to Audits?*

	The Chief Executive explained that national audits are published and helpful as a benchmark. The Committee NOTED and APPROVED the paper. **c) Proposed Clinical Audit Plan 2021/22** Tier 1 included National Clinical Audits and Outcome Reviews, Tier 2 would be set within departments and passed on to leadership and management. There were other Audits underway with GPs, which would be part of their appraisals. The information from these Audits was not being fully captured and it was intended to progress this in order to increase the learning that was available within Powys. Tier 4, would help reflect on the current commissioning services and out of county providers. A slightly amended programme for the 2021/22 period was proposed. The Committee NOTED and APPROVED the paper.
EQS/20/93	**Annual Data Quality Report** The Director of Finance and IT Services presented the paper outlining the findings from the Annual Data Quality Report 2019/20. This described the achievements made by the Information Department against the national targets for data quality and submission to NHS Wales Informatics Service (NWIS) for statutory reporting of mandated datasets. The report looked at compliance and accuracy of clinical coding, along with additional work that had taken place during the financial year, to improve data quality in other areas within the remit of the Information Department. The specification of the report had been agreed nationally by the Information Quality Improvement Initiative (IQII). Clinical Coding had exceeded the national target and maintained 100% compliance against a 95% target. WCCIS captures the target improvement areas and PTHB had played a national role by driving change for Maternity services. There have been additional outcomes introduced, the majority relate to digital and virtual consultations, which had been increased due to COVID-19. *Are the issues identified the same issues that were not rectified last year? If was not in Powys Teaching Health Board's what opportunities would there be to influence matters?*

	The Director of Finance and IT confirmed that this would require checking and this point would be addressed after the meeting. The Committee NOTED the report.
EQS/20/94	**Once for Wales Complaints Management System, Programme Update** The Director of Finance and IT presented the report which focused on providing a status update for the implementation of the Once for Wales Concerns Management System (OFWCMS). To support the implementation of the OFWCMS electronic tool, work had commenced to move the 3 workstreams, previously suggested as Systems, Processes and Safety into two areas for consistency with the national programme; 1. Technical Workstream 2. Functional Workstream Within which there were 20 work streams. Work had progressed in areas of the incident module and the mortality module. Key pieces that have been completed recently were; establishing a clear governance structure for the group, a full review of representation and attendance at the national groups. There had also been a review of the current policies to ensure that they were fit for purpose and identified if there were any gaps. *There were three overarching issues - this was a national piece of work but did the Health Board have a responsibility to ensure that the programme had been taken forward? What safeguards were in place relating to patient information?* The Director of Finance and IT responded that the OFWCMS was a system that would be used across Wales, would aim to assist in reporting and consistency. It would be considered as shared learning across the organisations and would bring a standardised approach. This was a system which was available and it was for the Health Board to decide how to use it including the policies surrounding it and how to safeguard patients. All of those concerns would be within the Health Board's control. *Is the overall system secure?* The Director of Finance and IT explained that this was a longstanding debate across organisations. All the DPIA's and Information Governance issues have been signed off at

	a national level. There were mechanisms in place to protect data sharing. *Will there be staff training in using the system and in terms of behaviour, values and duty of candour?* The Director of Finance and IT explained that staff training was a key component of the work stream. Including ensuring that the right people were identified that needed access to the system for data input and reporting and how people needed to act in terms of candour. The Committee NOTED and APPROVED the current position and risks and REVIEWED the 4 action areas.
ITEMS FOR INFORMATION	
EQS/20/95	**Review of Committee Programme of Business** The Chairs stated that the Committee Programme of Business stands as is.
OTHER MATTERS	
EQS/20/96	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND OTHER COMMITTEES** There were no items for inclusion in this section
EQS/20/97	**ANY OTHER URGENT BUSINESS** No urgent business. The Committee Chair thanked all members.
EQS/20/98	**DATE OF THE NEXT MEETING** 4 February 2021, Microsoft Teams.

Key:

Completed
Not yet due
Due
Overdue
Transferred

EXPERIENCE, QUALITY & SAFETY COMMITTEE

ACTION LOG 2020/21

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Minute	Meeting Date	Action	Responsible	Progress Position	Completed
Arising from Meetings of the Experience, Quality & Safety Committee (2020/21)					
ARA/20/82	3 November 2020	Internal Audit Report: Fire Safety (Limited Assurance). A follow-up report to be presented to the Experience, Quality and Safety Committee.	Board Secretary / Director of Workforce & OD and Support Services	Action transferred to the Experience, Quality & Safety Committee Action Log, as requested by ARA Committee (November 2020)	**NEW**
Arising from Meetings of the Experience, Quality & Safety Committee (2019/20)					
EQS/19/89	4 February 2020	Information regarding how PTHB receive assurance that visiting clinicians are compliant with training will be circulated with Committee Members.	Assistant Director of Quality & Safety	1 October 2020 It was confirmed that the Quality and Safety team are following up on this action. The Medical director confirmed his support in resolving the action.	

EQS/19/76	3 December 2019	The Research and Development and Innovation Update report was requested to be strengthened and taken forward in conjunction with the Clinical Quality Framework.	Medical Director	<u>03 Dec 2020</u> It is proposed that an update on Research and Development is built into the Committee's workplan for 2021/22 <u>16 April 2020</u> The Committee agreed that in light of COVID-19, this action would be deferred to Q3, 2020/21 (priority 2).	

EQS/19/22	4 June 2019	HIW/CIW Joint Inspection: Community Mental Health – The Hazels (Llandrindod Wells) – where 'The Hazels' building sits in the asset refurbishment programme will be confirmed at the next meeting	Assistant Director of Estates and Property	<u>28 January 2021</u> Programme Business Case for Llandrindod (£11M+) was submitted to Welsh Government in December 2020, currently awaiting endorsement and this includes a funding allowance for The Hazels block reconfiguration / refurbishment. Additionally, £50K has been included in the discretionary capital programme for 2021/2022 for more immediate remedial repairs, subject to Board approval. <u>03 Dec 2020</u> An update on this item will be provided to the Committee in February 2021. <u>16 April 2020</u> It was confirmed that due to pressure on the Estates Department as a result of	

				COVID-19, this item would be deferred to Q3, 2020/21 (Priority 3).	

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.1

EXPERIENCE, QUALITY & SAFETY COMMITTEE	04 February 2021
Subject:	**CONCERNS (COMPLAINTS, CLAIMS AND PATIENT SAFETY INCIDENTS)**
Approved and Presented by:	Alison Davies, Executive Director of Nursing & Midwifery
Prepared by:	Wendy Morgan, Assistant Director Quality & Safety Rebecca Membury, Senior Manager Putting Things Right
Other Committees and meetings considered at:	

PURPOSE:

The purpose of this report is to provide the Experience, Quality and Safety Committee with a summary of patient experience and concerns, including complaints, patient safety incidents and claims for November and December 2020. The report also outlines serious incidents reported to Welsh Government and enquiries received from Her Majesty's Coroner.

Recommendation(S):

The Experience, Quality & Safety Committee are asked to discuss and note the contents of this report.

Approval/Ratification/Decision	Discussion	Information
✖	✓	✖

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	×
	2. Provide Early Help and Support	×
	3. Tackle the Big Four	×
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	×
	6. Promote Innovative Environments	×
	7. Put Digital First	×
	8. Transforming in Partnership	×
Health and Care Standards:	1. Staying Healthy	×
	2. Safe Care	×
	3. Effective Care	×
	4. Dignified Care	×
	5. Timely Care	×
	6. Individual Care	✓
	7. Staff and Resources	×
	8. Governance, Leadership & Accountability	✓

DETAILED BACKGROUND AND ASSESSMENT:

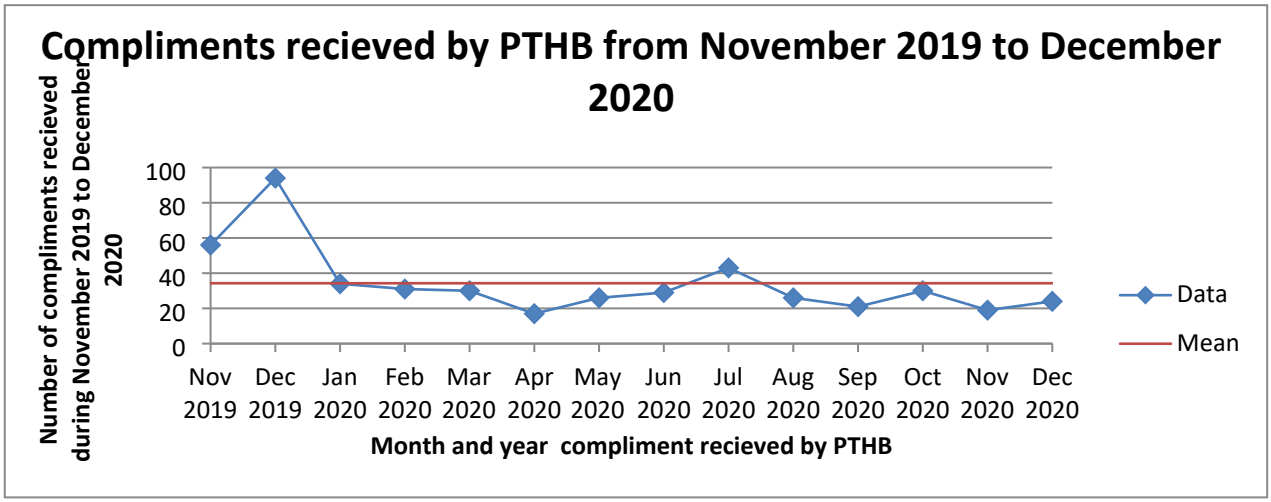
The data depicted within this report is taken from the Datix system, unless otherwise specified, and is correct at the time obtained. The data quality and confidence are subject to limitations of the current Datix system, which is subject to change as part of the Once for Wales Concerns Management System initiative, due for implementation by April 2021.

1.1 Compliments

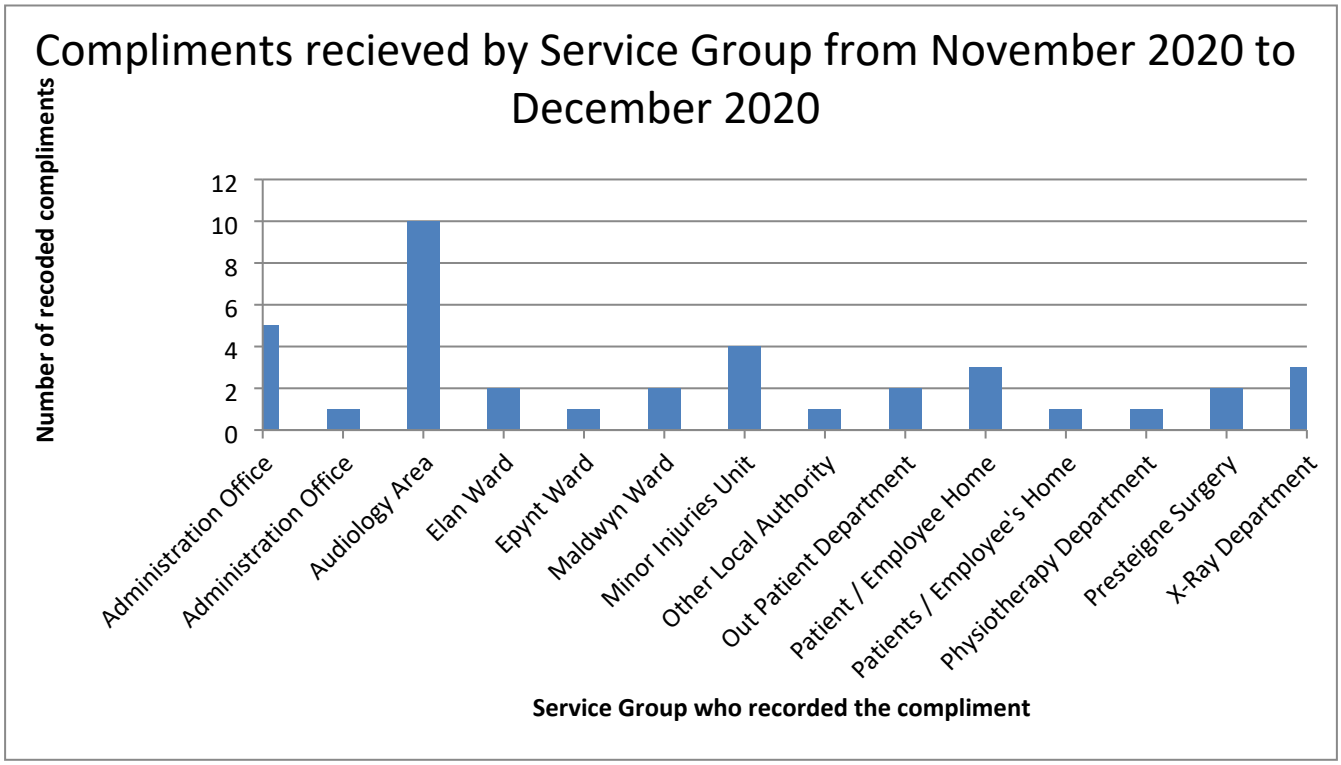
Between 01 November 2019 to 31 December 2020, a total of 480 compliments have been received by the health board from patients and relatives. These consisted of a combination of cards, and small tokens such as chocolates, expressing thanks and appreciation for kindness, compassionate care and support provided.

During the reporting period of 01 November 2020 to 31 December 2020, the health board received 44 compliments with the Audiology Department continuing to have the highest number of compliments recorded for this time period. The graph below illustrates a broadly similar pattern in relation to compliments over the last few months, where the way in which services are delivered has been altered as a result of the pandemic. This indicates the need for new and different ways to understand patient experience of new or different models of service delivery and will be a focus of the patient experience group into the future, along with the wider patient experience agenda, when this group is reconvened.

Graph 1 – Total number of compliments received between 01 November 2019 to 31 December 2020



Graph 2: Compliments by Service Group during the period of 01 November 2020 to 31 December 2020



1.2 Complaints

Informal concerns, often termed 'on the spot' concerns usually relate to issues which can be resolved quickly. All concerns, informal and formal, are required to be acknowledged within two working days. Our internal target for the acknowledgement of informal concerns is 100%. During the period of 01 November 2020 to 31 December 2020 the health board achieved 86% of this target. During the same period, the health board achieved 85.3% target in acknowledging formal concerns, this complies with Welsh Government targets although the intention is to improve in this area.

The health board set an internal target of 90% of informal concerns to be responded to within the new Welsh Risk Pool Services and Welsh Government target of 2 working days. From 01 November 2020 and 31 December 2020, the health board received 5 informal concerns, one of which escalated to a formal concern, the remaining 4 were successfully managed as informal concerns

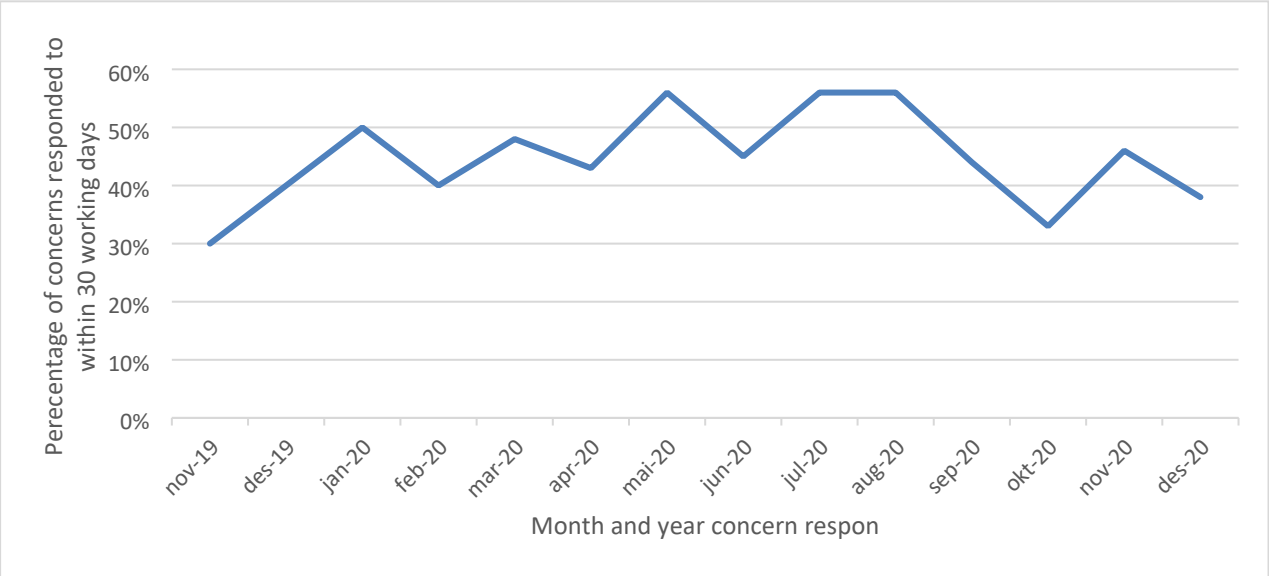
During 01 November 2020 to 31 December 2020 the health board received 43 formal concerns. The main issue remains accessing services, including delays in surgery and inability to access primary care, in particular, difficulty arranging appointments in a timely manner with a General Practitioner. the impact of restrictions resulting from the Covid19 pandemic have resulted in difficulties in accessing care and treatment for the residents of Powys, whether the service is provided by primary care, Powys Teaching health Board or commissioned services.

The health boards recovery planning and proactive discussion with commissioned services are aimed at securing a risk-based return to service provision.

During this period, the health board responded to 42% of formal concerns within the 30-working day target, this is lower than previous months. Since December 2020, the Assistant Director of Quality and Safety's portfolio has been temporarily reduced to help deliver on the improvement trajectory in place to reach a 0% position on outstanding concerns. Please note this does not mean the absence of concerns within the system, the health board greatly values the opportunity to receive, address and learn from concerns wherever possible, the target aims to support the timely response to concerns raised.)

In support of improvement, the full and final report resulting from the independent review is expected imminently, which, along with the broader internal review, will be used to inform further improvement activity.

Graph 3 – Percentage of concerns responded to within the 30-day target from November 2019 to 31 December 2020



Data Source: IFOR

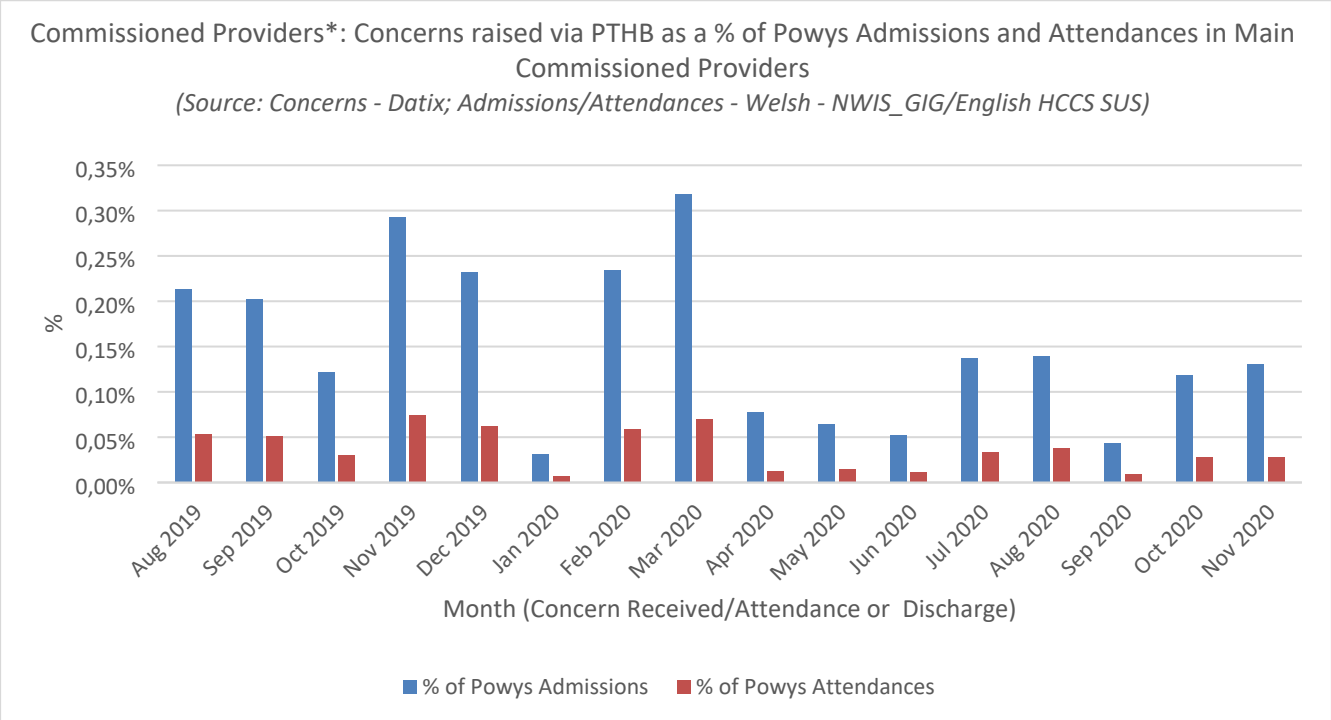
1.2.1 Concerns raised about Commissioned Services

During 01 November 2020 to 31 December the health board received notification of 7 concerns relating to commissioned services from differing sources, 3 related to Aneurin Bevan University Health Board, others related to services provided by Welsh Ambulance Services Trust, Birmingham, Shrewsbury and Telford NHS Trust and Wye Valley Trust. From review there are no themes or trends identified during this period. From analysis of one year's period from 01 August 2019 to 30 November 2020 it can be seen from the graph below the number of concerns raised during the same period in 2019 are comparable. There is a decline in concerns being raised via the health board during quarter 3 this could be due to the reduction

of services being offered and the number of patients utilising the commissioned services.

The data in the charts below has been captured and analysed on the basis that the patient admissions/attendances are used as a monthly denominator to give a context to the number/proportion of complaints. It is to be noted that there is no suggestion that complaints in a particular month were made by patients who attended or were admitted in that particular month.

Graph 4: Concerns raised via Powys Teaching Health Board all Commissioned Services providers to November 2020



1.3 Learning and improving from concerns, patient experience and incidents

This is a key focus for the health board. Reports on learning are presented to the quarterly Patient Experience Steering Group meetings as well as individual learning through wards and departments, newsletters, and 'you said, we did' boards. The Medical Director is chairing the first of the health board's learning group imminently. Regular updates are provided via Powys Announcements regarding sharing of learning in relation to COVID19, supporting early sharing of the wider learning captured by the Delivery Unit, related to in-hospital transmission of Covid-19 (CoRSEL). Recent examples of improvement include:

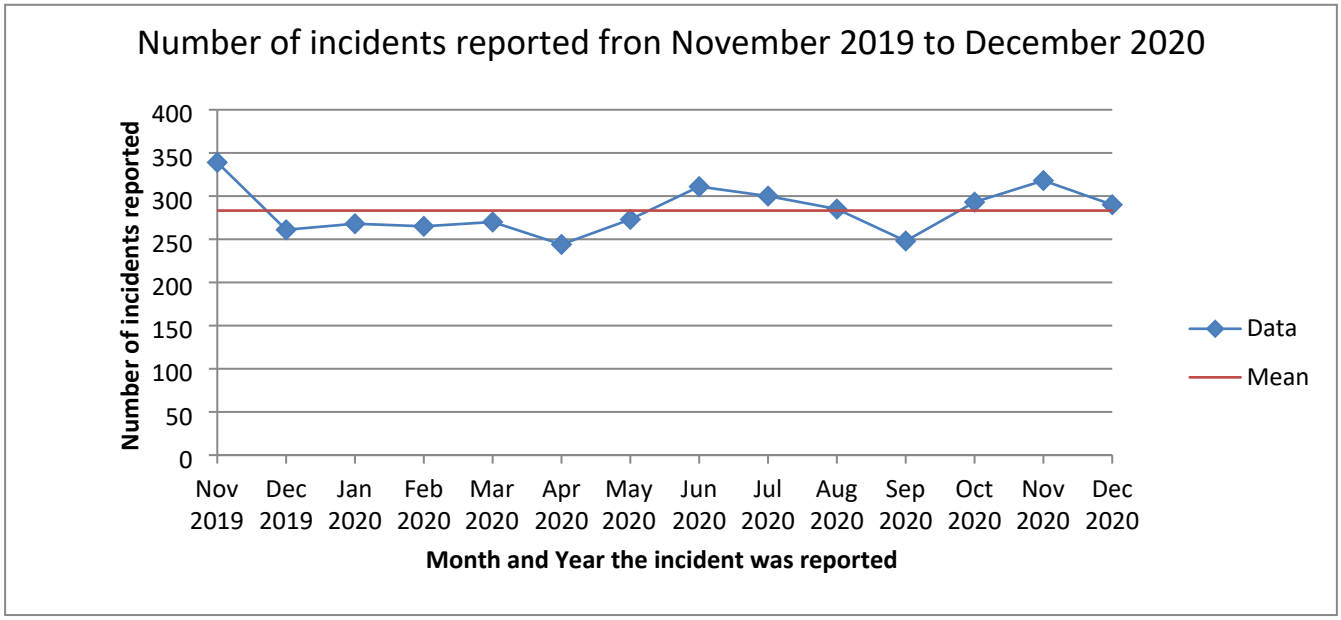
- Developing a consistent approach to referrals and information sharing between teams in mental health services, along with creation of a process for sharing risk assessments and Care and Treatment Plan's with services, including non-statutory services who are involved in patient care. A multi-agency working group will be undertaking this work.
- The Testing Service has introduced changes to practice in relation to retesting

of people who are within 90 days of a previous test to avoid the risk of unnecessary self-isolation.

2. Incident Reporting by Service Group

During the period 01 November 2020 to 31 December 2020, there have been 608 reported incidents (graph 12), which is reflective of the overall average for the health board (see graph 13 below).

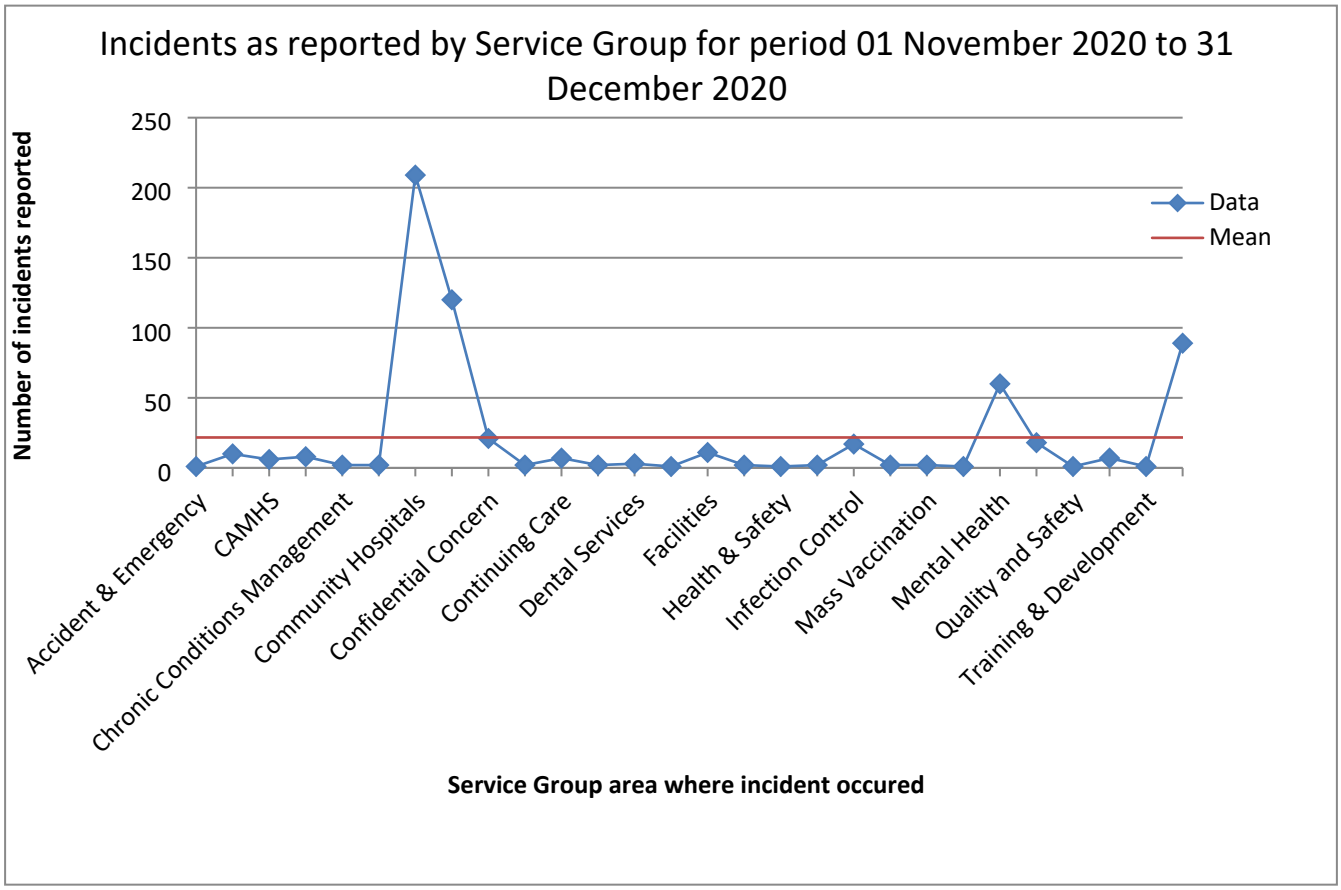
Graph 12: Incidents reported 01 November 2019 – 31 December2020



It is noted over the last year there is variation in the number of incidents reported month on month, the range 213-339, and average of 283 incidents per month has been maintained over this period. A total of 3,965 incidents reported for the whole year, a reduction is noted in the month of April 2020, which may reflect the reduced activity and low bed occupancy as a result of Covid-19. A decline in reporting since June 2020 is noted albeit with a slight increase in November 2020, and the incidents remain lower than this time last year, possibly related to changes to service delivery as a result of the COVID19 pandemic. The decline is being reviewed for any identifiable trends or themes being identified as a result of the decline.

Incidents increased between May – July 2020, decreased in August and September 2020, then increased again during October and November2020. There are a number of factors that may affect reporting rates, including lower bed occupancy during this period. It is noted that there is an increase in incidents being reported being linked to the patient's home, the increase could be due to greater activity in care being provided at home, increased awareness, increased reporting and strengthened nurse leadership via the Head of Nursing, who continues to monitor for themes or trends. It will be noted that the Community Hospitals, Mental Health and Women and Childrens Services have higher levels of reporting.

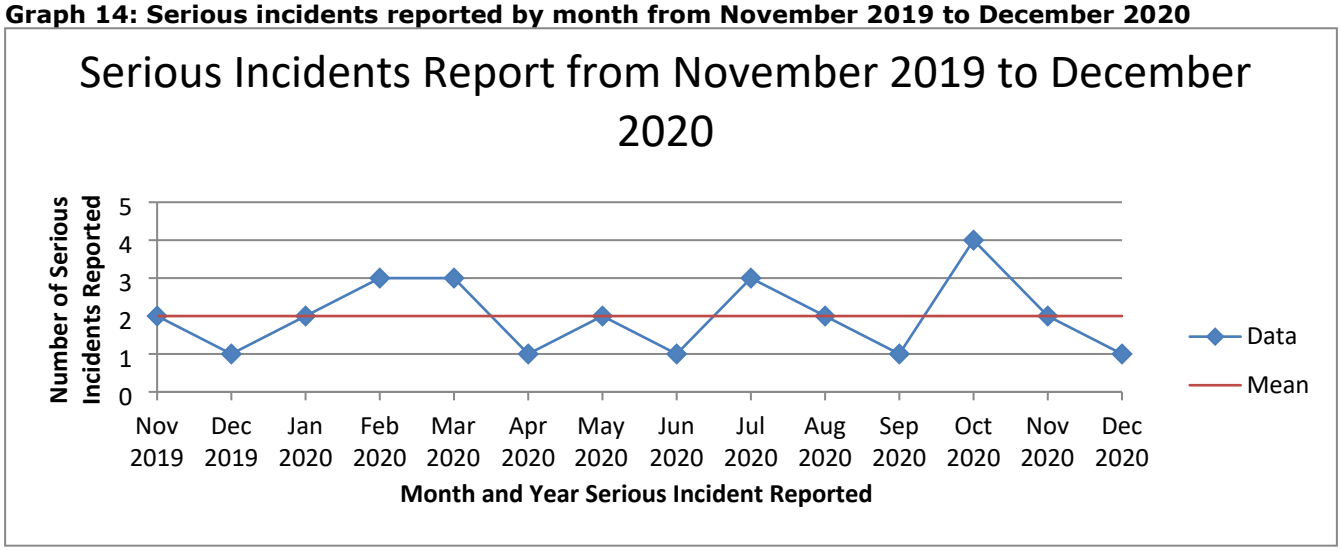
Graph 13: Incidents by service group 1 November 2020 to 31 December 2020



2.1 Serious incidents

A serious incident is defined as an incident that occurred during the provision of NHS funded healthcare. During the period of 01 November 2020 to 31 December 2020 the health board reported less than 5 serious incidents to the Delivery Unit which were reported by the following Service Groups, Mental Health, Women and Children Services Group and the Community Services Group. The number of serious incidents within the health board remains below 5 per month, it is important to note that whilst numerical representation is important, the health board primary seeks assurance that issues that are serious are reported as such. As part of the implementation of the Clinical Quality Framework, an audit of incident reporting aligned to mortality reviews is planned and will take place when the health board as part of the health board's recovery planning.

Graph 14: Serious incidents reported by month from November 2019 to December 2020



3. No surprises notifications

Welsh Government are notified of sensitive issues via a process known as 'no surprises' these are closed automatically within 3 working days. Between 01 November 2020 and 31 December 2020, the health board have made less than 5 reports to Welsh Government, these included (not exclusively) issues related to care and treatment in commissioned services and medication related matters.

4. Inquests

During the period of 01 November 2020 and 31 December 2020 there have been less than 5 HM Coroner Enquiries opened. As a result of the Covid19 pandemic, HM Coroner Courts have been advised to hold inquests remotely to avoid further delays. The HM Coroner is currently considering alternative means by which to undertake inquests and from August and until 31 December 2020, it is noted that dates are now being listed with the caveat of significant delays likely to exceed the 6 months' timescale detailed in the Coroners Rules, 2009.

5. Public Service Ombudsman for Wales

If a patient remains dissatisfied with a response to a concern investigated by the health board, the complainant has the right to raise the matter the Public Services Ombudsman (PSOW). The PSOW determines whether to pursue a full investigation, with the authority to impose sanctions on the health board by way of financial compensation to the complainant. In addition, there PSOW can issue a Public Interest Report and reports issued under Section 16 or Section 21. During the period of 01 November 2020 and 31 December 2020, the health board have received less than 5 PSOW enquiries, and successfully managed two of the recommendations made by the PSOW and an agreement has been made with the PSOW to extend the timescale to finalise an outstanding Standard Operating

Procedure due to the complexity involved.

6. Claims

Powys Teaching Health Board has a small claims portfolio; there are currently 16 open which are inclusive of clinical negligence and personal injury claims with one case transferring from a potential claim during quarter 3, with NWSSP Legal and Risk Services instructed to act on behalf of the health board. The health board currently have less than 5 personal injury cases being managed by NWSSP Legal and Risk Services. From review of the claims for the health board there have been no identified themes and trends.

7. Patient Safety Solutions

Performance for all Health Boards and Trust in Wales can be found at **http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data**

Action has been taken to progress compliance with the three open patient safety solutions indicated as non-compliant (PSN 034, 051 and 052).

PSN 034: Supporting the introduction of the National Safety Standards for Invasive Procedures – action is progressing to support compliance, the appointment of new senior nurse roles in Theatres and Outpatients Department will support completion of this work. Quarter 1 2021/22 will report further compliance.

Compliance regarding 4 patient safety notices has been reported to Patient Safety Wales:

- PSN 051 Depleted batteries in intraosseous injectors – not applicable to Powys Teaching Health Board
- PSN 052 Risk of death and severe harm from ingesting superabsorbent polymer gel granule – Compliant
- PSN 053 Risk of harm to babies and children from coin/ button batteries in hearing aids and other hearing devices – Compliant
- PSN 054 Risk of death from unintended administration of sodium nitrite – Compliant

Two new notices have been received:

- PSN 055 The Safe Storage of Medicines: Cupboards – action required by 30th September 2021(notice replaces PSN 030 issued in 2016)
- PSN 056 Foreign body aspiration during intubation, advanced airway management or ventilation- action required by 1 July 2021

Agenda item: 3.2

Experience, Quality and Safety Committee	**4 FEBRUARY 2021**
Subject:	**Regulatory Inspections Report**
Approved and Presented by:	Alison Davies, Director of Nursing & Midwifery
Prepared by:	Helen Kendrick, Quality and Safety Manager Ruth Derrick, Head of Mental Health Nursing
Other Committees and meetings considered at:	N/A

PURPOSE:

The purpose of this report is to inform the Committee of the undertaking of regulatory inspections that have occurred during this reporting period, the outcomes as they become available and progress against the Health Inspectorate Wales dashboard.

RECOMMENDATION(S):

The Experience, Quality & Safety Committee are asked to DISCUSS the contents of this report.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✓
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✓
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The health board strives for continuous quality improvement supported by a number of enablers, including recommendations resulting from regulatory inspections. During the previous reporting period, the health board has received 4 Tier 1 Quality Checks from Health Inspectorate Wales, with a high number of positive findings, along with a low number of improvements required. An overview of the current position relating to the implementation of recommendations following HIW inspections identifies some progress.

Health Inspectorate Wales have provided an update position on their adapted approach to assurance and inspection during the Cocid19 pandemic, along with the publication of the Quality Insight Bulletin.

DETAILED BACKGROUND AND ASSESSMENT:

1. Health Inspectorate Wales Inspections

1.1 Tier 1 Quality Checks

On 18th December 2020, HIW wrote to the Chief Executive Officer and Chair of the health board (appendix 1), advising of the continuation of Quality Checks as a means of gaining assurance into 2021, with a pause until at least the end of January 2021, given the adverse effects of the pandemic on NHS capacity. The potential to undertake inspection activity reactively remains.

Reference to the Quality Insight Bulletin was made, the bulletin captures themes and trends, good practice and emerging risks identified following Quality Checks undertaken across Wales. A second update is expected in February 2021 with a final report to follow in the Spring. The Quality Insight bulletin can be accessed via the following link: Arsylwi ar Ansawdd (COVID-19) AGIC / HIW Quality Insight (COVID-19)

The Committee has previously been informed the health board has been in receipt of four Tier 1 inspections to date and the Findings Reports for each above have previously been shared. For those areas where improvement plans were required, an update is required by HIW within 3 months of the inspection date. The health board submitted an updated improvement plan for Tawe Ward, Ystradgynlais Hospital on 11th December and is awaiting a response from HIW.

On 1 December 2020, HIW undertook a remote Quality Check of Haygarth Medical Centre as part of its programme of assurance work. As with the general hospital inspections the focus was on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The Findings published by HIW on 29th December 2020 identified several examples of positive evidence with no areas for improvement. The findings can be reviewed at the following link or in *Appendix 6.* https://hiw.org.uk/sites/default/files/2020-12/20201229HaygarthEN.pdf

1.2 Review of Healthcare Services for Young People

HIW wrote to the health board on 11th September 2020 in relation to the published review "How are healthcare services meeting the needs of young people?" HIW requested information and assurance around the actions the health board has implemented, is currently taking, or planning to take to address the issues raised in the review. The health board has submitted this information to HIW and awaits a response. Feedback is awaited. The review can be viewed at the following link:

HIW publishes review of healthcare services for young people | Healthcare Inspectorate Wales

1.3 National Review of Maternity Services

On 19th November 2020. HIW published the report for Phase one of its National Review of Maternity Services. The review set out to specifically assess how women perceive the care available to them; how it is delivered and whether quality and safety is maintained throughout the experience. The review has also considered how staff working within the services were supported and encouraged to undertake their relevant roles. The report can be accessed via the following link and in *Appendix 2.* https://hiw.org.uk/sites/default/files/2020-11/20201118HIWNationalReviewofMaternityServicesEN_0.pdf

The services provided by Powys Teaching Health Board are well reflected and an example of noteworthy practice is identified related to Birth Reflections, a service provided by midwives to allow women and their families to explore their birthing experiences, giving an opportunity to gain clarity around any issues they may have encountered during the birth. The HIW report for Community Hospital Free Standing Birth Units for Maternity Services in Powys is available via the following link and in *Appendix 3.* https://hiw.org.uk/sites/default/files/2020-07/HIW%20-%2019287%20-%20Powys%20Home%20from%20Home%20Birthing%20Centres%20-%20Final%20Published%20Translation%20Report.pdf

2. Health Inspectorate Wales Recommendations and Tracker

Appendix 4 provides details the current position in terms of addressing the recommendations resulting from HIW inspections. Progress has been made and Committee will note there is a clear position in terms of the areas where actions remain to be completed, the majority of which occur within mental health services, where all outstanding actions are under regular review. Appropriate risk mitigation is in place and action plans are monitored by the service area Quality and Safety Team, with oversight and governance maintained through the Mental Health and Learning Disability Senior Management Team. A review of the position is scheduled for the end of March 2021, where revised completion dates will be set at the earliest possible point.

The National Review of Services for Young People will be included in monitoring process as soon as HIW have approved the improvement plan submitted by the health board and the final report published. Validation of the tracker continues by the Quality & Safety Team to ensure a current position on progress against all recommendations is captured.

3. Care Inspectorate Wales (CIW)

The Committee is aware that on 12 March 2020 CIW undertook an inspection of Cottage View Care Home, Knighton. Cottage View provides care and support for up to ten people. The registered provider is Powys Teaching Health Board with an appointed responsible individual (RI) to oversee the operation of the service. A manager has day-to-day responsibility and is registered with Social Care Wales (SCW).

On 29 October 2020 the health board received a Notice of Decision under s.20 (2) of the Regulation and Inspection of Social Care (Wales) Act 2026 advising the application to grant the Assistant Director Community Services Group as the Responsible Individual for Cottage View and the Conditions of Registration are recorded. The Notice can be viewed in Appendix 5. The health board awaits the final report and notice of the intended date of publication.

4. Community Health Council

There have been no recent visits by the Community Health Council.

Direct Line: 03000 628120
E-mail: Alun.Jones39@gov.wales

Chief Executive and Chair
Powys University Health Board
Via Email

18 12 2020

Dear Carol and Vivienne

COVID-19 Quality Insight bulletin and NHS quality check and inspection pause

I wrote to you in July and again in October to set out how HIW was adapting its approach to assurance and inspection at a time when on-site inspection visits have been far more challenging for both healthcare settings and ourselves.

We launched our programme of Quality Checks in August, and at the end of October we had conducted 43 Quality Checks, published 26 summary findings reports and issued 2 immediate assurance letters. We have sought to communicate our findings as quickly as possible to support improvement and so that they can be considered by settings in their ongoing management and response to the pandemic. We also took the opportunity to feedback initial findings at the NHS Executive Board and the feedback we received was helpful in refining our approach.

To further support improvement, we have now considered all of the findings from our Quality Checks during this period and captured the positive themes, good practice and emerging risks. Our Quality Insight bulletin (attached) presents this information and will be distributed via e-mail across NHS and independent healthcare services, as well as being published on our website.

Link to COVID-19 Quality Insight bulletin

I hope you find the bulletin useful, and if so, would request that it is shared within your organisation.

This is the first of two such updates we intend to issue, with the second in February. We will produce a final report in the spring. To receive future updates directly, please contact hiw.comms@gov.wales to request this and you will be added to the distribution list.

Finally, whilst we will be continuing with Quality Checks as a means of gaining assurance into 2021, given the continued and significant pressures that NHS services face as a result of the pandemic, I have taken the decision to pause routine Quality Checks and Inspections in the NHS from 24 December until at least the end of January. It may, however, still be necessary to carry out inspection activity where there is a very high, imminent risk to patient safety.

We will continue to discharge our functions through our broader assurance work during this period. As always, I welcome feedback on our work, so if you have comments or observations, please feel free to contact me.

Best Regards,

Jones, Alun
01/28/2021 13:50:50

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Llywodraeth Cymru / Welsh Government
Parc Busnes Rhydycar / Rhydycar Business Park
Merthyr Tudful / Merthyr Tydfil
CF48 1UZ
Tel / Ffôn 0300 062 8163
Fax / Ffacs 0300 062 8387
www.hiw.org.uk

Alun Jones
Interim Chief Executive
Healthcare Inspectorate Wales

Cc.
Chair: Vivienne.Harpwood@wales.nhs.uk
Medical Directors: paul.buss@wales.nhs.uk & catherine.woodward@wales.nhs.uk
Director of Nursing: alison.davies27@wales.nhs.uk
HIW Relationship Manager: Rebecca.Collier@gov.wales

Llywodraeth Cymru / Welsh Government
Parc Busnes Rhydycar / Rhydycar Business Park
Merthyr Tudful / Merthyr Tydfil
CF48 1UZ
Tel / Ffôn 0300 062 8163
Fax / Ffacs 0300 062 8387
www.hiw.org.uk

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

National Review:

Maternity Services

Phase One

National review of the quality and safety of maternity services

Content

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

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

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

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice.

Influence policy and standards:
Use what we find to influence policy, standards and practice.

Foreword

In its 2019-20 Operational Plan, Healthcare Inspectorate Wales (HIW) committed to a programme of national reviews which included maternity services. Our decision to undertake this review was based on a number of concerns relating to the pressures around maternity services in Wales, including the issues identified during HIW's inspection of maternity services at the Royal Glamorgan Hospital in the former Cwm Taf University Health Board[1] in October 2018, and the subsequent Royal College of Obstetricians and Gynaecologists report of the former Cwm Taf University Health Board in April 2019[2].

At time of writing, health and care services across Wales have had to rise to meet the challenges of a global pandemic, COVID-19. This has introduced unique and unprecedented pressures on the system that will continue through the winter months. Services have adapted, changed and expanded to cope with these pressures and the response across Wales has to be commended.

It is important to highlight that this review and fieldwork were undertaken between June 2019 and January 2020, prior to the COVID-19 pandemic, and publication of this report was delayed due to measures we took to reduce the burden of our work on services during the height of the pandemic. As such, our review has not examined in any way how maternity services across Wales have undertaken their role, or responded during the pandemic.

Our National Review of Maternity Services out to specifically assess how women perceive the care available to them; how it is delivered and whether quality and safety is maintained throughout their experience. The review has also considered how staff working within the services were supported and encouraged to undertake their relevant roles.

This report brings together the findings from the first phase of our national review, which consisted of a programme of inspection, document review, interviews, and comprehensive surveys of the public and staff working in maternity services. This report highlights the key themes, good practice and recommendations for improvement, to have emerged from our work so far.

We would like to express our sincere thanks to all who have participated in this review, and in particular to the women and families who participated and shared their views and experiences with us. The views and opinions from all contributors, have been considered to help develop our findings and recommendations.

[1] Since 1 April 2019, Cwm Taf University Health Board became Cwm Taf Morgannwg University Health Board following the incorporation of the Bridgend area within the health board.

[2] See: https://gov.wales/review-maternity-services-former-cwm-taf-university-health-board

Summary

This report set out the findings from the first phase of our National Review of Maternity Services across Wales, which explored the extent to which health boards across Wales provide safe and effective maternity services.
The key findings are as follows.

Our overall view is that those working within maternity services across Wales are extremely committed and dedicated to providing the best standard of care to women and families. It is clear that the various professionals working in maternity services take great pride in what they do, and strive to ensure that the journey through the pregnancy pathway is as positive an experience as possible. We believe that the quality of care is good, and that maternity services in general are delivered in a safe and effective way.

This is supported by the responses we had to our public surveys, with the overwhelming majority of respondents satisfied and positive with the standard of care and support that they received along each stage of the maternity pathway. We have however, identified some areas for improvement.

Is the care given well informed, individualised and family centred?

Overall, we found that care being delivered within maternity services across Wales was of good quality, well informed, individualised and family centred. It is clear that women were generally positive about the care and communication they received from services at each stage of their pregnancy. It is also clear to us that those working within maternity services are committed and dedicated to providing the best possible care they can. However, there are some themes and messages that have emerged from our review that require attention, with a particular focus on communication and consistency of care.

We heard concerns regarding whether women feel their views are listened to, valued, and responded to. Whilst women generally feel well supported, and were given enough information in order to make informed choices about their care, a number did not feel that they were able to express opinions and concerns about their birth choices, or felt ignored. Whilst there may be medical reasons why individual birth choices cannot always be followed, our survey suggests that this is an issue that needs to be explored further across Wales.

It is also evident that more needs to be done to ensure that women are able to communicate in their language of choice, enhancing the ability of women to feel heard and listened to, during what can be an uncertain and frightening time. Further to this, there is an inconsistency in the ability of partners or families to be present at all stages of the maternity pathway. We believe that open visiting should be available at all units across Wales.

We noted concerns raised by women regarding continuity of care. In particular, these concerns related to women feeling that they did not receive consistent care due to the number of professionals that they saw on their pregnancy journey. This impacted on, or impaired, their ability to build a rapport or relationships with a small group of healthcare professionals, and had a detrimental impact on the woman's perceived continuity of care. It can be traumatic for women to have to repeatedly recall or recount their medical history, or perhaps traumatic birthing or pregnancy experiences to different healthcare professionals. It can be difficult to ensure that women see the same professionals throughout their pregnancy, however, we feel that this is an area in need of focus nationally.

Generally, the level of support, advice and guidance for women and families was positive, with good examples evident of health boards promoting positive health and well-being initiatives throughout pregnancy. Whilst breastfeeding is well promoted across Wales, there are concerns raised by both women and staff over the ability to provide sufficient breastfeeding support, as this is often hampered or restricted by staff numbers and workload. This is an area requiring improvement generally.

Of particular concern is the need for further attention around the adequacy of perinatal mental health support available to women. An inadequacy of mental health support can have a severe and lasting impact on women. We believe that mental health support requires focus and improvement nationally, to ensure appropriate support is available in times of crisis. If left untreated, mental health issues can have significant and long lasting effects on woman, their baby and the wider family.

Bereavement services and support were generally adequate, but access to timely bereavement training for staff requires improvement. We did note some positive initiatives by some health boards in providing support services to women who have suffered traumatic experiences.

One of the key areas that requires attention across Wales relates to health boards sharing outcomes and changes, that have been implemented as a consequence of feedback provided by women or families about their experiences. We believe that there is an opportunity for services to demonstrate how they adapt and change in response to issues raised by women and families.

Are women in Wales receiving safe and effective care?

The majority of our findings in relation to this question are based upon the programme of inspections we undertook of all maternity units across Wales. Whilst we found adequate processes in place across Wales to provide women with safe and effective care, we did identify a number of patient safety concerns.

It was disappointing to note how often we identified issues around the checking of neonatal resuscitaire and emergency equipment, medical emergency arrangements, security of newborn babies, environment of care, and medicines management. Although these concerns did not directly impact on the quality of care being provided to women and babies during our inspection, they increased the risk of an issue occurring which could have a significant impact upon patient safety. Each of these issues were addressed through our Immediate Assurance process, and each health board has since provided us with the appropriate assurance following identification of these concerns.

We were generally satisfied with arrangements around safeguarding, and found additional specialist knowledge and support was available in all units for a variety of issues. These included teenage pregnancy, domestic violence, asylum seekers and female genital mutilation.

We found that maternity services generally had clear and robust process for reporting and investigating clinical incidents and concerns. However, a clear issue that requires improvement relates to learning and service improvements as a consequence of incidents or concerns. We found that learning was not always shared with staff in a timely and effective way. This issue needs significant attention from all health boards to ensure that staff are able to deliver the best standards of care, safely.

Nearly half of all staff who responded to our staff survey felt that their organisation did not treat staff involved in incidents fairly. Additionally, a high number of staff with whom we spoke during inspection felt that incidents were dealt with in a punitive manner, with a blame culture evident. This is clearly an area of concern. If staff feel that incidents are not going to be managed in an open, and transparent way, it will serve as a deterrent to those wishing to raise concerns. Given the prevalence of this issue within the Royal College of Obstetricians and Gynaecologists' report of the former Cwm Taf University Health Board, this is an issue all health boards need to consider, with action being taken to do all it can to promote a positive reporting culture amongst all staffing groups.

Are women receiving care from skilled multi-professional teams?

In general, we found multi-professional team working was strong, and we identified effective working relationships throughout midwifery, medical, obstetric theatres, pharmacy teams and clinical research and innovation leads. This teamwork allowed for effective communication, enabling health boards to provide good care to women.

We saw evidence of innovative practice across Wales, including teams working together to implement noteworthy initiatives, such as Babies Don't Bounce, Epilepsy in Pregnancy and Practical Obstetric and Multi-Professional Training (PROMPT)[3]. Health boards need to do more to harness the opportunity of sharing good practice and innovations such as these across Wales.

Overall, we were satisfied with processes to ensure that staff were sufficiently skilled in their roles. Mandatory training compliance is acceptable, however, staff are not always able to undertake refresher training promptly due to workload and resource pressures.

Can the quality of services be sustained?

We have seen strong evidence of an extremely committed group of professionals, who are striving to deliver high quality care to women on their journey along the maternity pathway. However, there are risks in the ability of health boards to ensure that sufficient levels of staff are in place to enable the safe delivery of care at all times.

Whilst health boards were generally working in line with requirements such as Birth Rate Plus[4], it was clear from our inspections and survey results that staff are working under pressure, and feel that there are not enough staff to enable them to do their job properly. It is also evident that there are stresses and strains on the medical workforce, with on-call rota deficits and concern over compliance with working time directives. Our inspections found there to be a very strong team working ethos amongst staff within maternity units, despite the challenges they face. Staff covering other staff shortages to allow services to continue to function is a regular occurrence. It is clear that this good-will can have potentially detrimental effects on well-being and work-life balance, with potential implications for the quality of care being provided.

Whilst we appreciate that resolving staffing shortages is a challenging issue for health boards, they must ensure that they do all they can to maintain safe and effective delivery of care at all times.

[3] PROMPT – Practical Obstetric and Multi-Professional Training. Its importance is to train teams to be teams within their working environment.

[4] https://www.birthrateplus.co.uk/

How well are maternity services led and managed?

The way in which maternity services are led and managed has a significant bearing on the overall quality of care provided, and consequently upon the experience of those using the services. Overall, we have seen services led by a hugely committed group of service leads, endeavouring to provide the best level of care, and deliver a positive experience for women and families. As our public survey has demonstrated, the majority of women were pleased with the level of care and support that they received at each stage of their pregnancy.

Our programme of inspections have nonetheless highlighted some concerns over the effectiveness of the management of some maternity units. It has been striking to note how consistently we identified patient safety issues, which gave rise to concern over local management and governance arrangements of these units. It is clear that there is room for improvement, to ensure that safe and effective care is being provided consistently across Wales.

Whilst we did not note any significant concerns with governance oversight of services in each health board, we did identify areas for improvement. In general, clear organisational structures are in place throughout Wales, with clear lines of reporting and accountability. Across our inspections we found that in general, risk assessments and risk registers were completed and maintained, and were updated regularly. We also found during our governance work that executive teams and boards monitored high risks regularly, with each health board holding monthly governance meetings that considered risks and clinical incidents and assigning actions as applicable.

While we did not identify any concerns regarding under reporting of clinical incidents in any health board, there is significant room for improvement in ensuring that trends, themes and learning arising from incidents are effectively shared with staff, in order to improve the quality of care. Significantly, we feel there remains work needed for all health boards in relation to ensuring a positive, clear and transparent culture is present within their maternity services. This in particular was evident in relation to the negative perception amongst staff about the way they would be treated if they reported incidents or concerns. This is an incredibly important issue that demands attention, given that the culture of a service has a direct impact upon the quality and safety of care that is provided to women and families.

Context

The Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) were commissioned by Welsh Government in October 2018, to carry out an independent review of the maternity services at the former Cwm Taf University Health Board. This followed serious concerns that initially came to light as a consequence of the under reporting of serious incidents in its maternity services.

Their review report [5] was published in April 2019, and raised a number of significant concerns around staffing, processes and the underlying culture in maternity services that compromised care. This resulted in Cwm Taf Morgannwg's maternity services being placed in to Special Measures in April 2019, under the NHS Wales Escalation and Intervention Arrangements[6].

Following the report's publication, and given the seriousness of this situation, the Minister for Health and Social Services required health boards to consider their own maternity services, in the context of the recommendations of the report, and to provide immediate assurances in this regard.

Welsh Government worked with Heads of Midwifery, Clinical Directors and user-led maternity service liaison committees, to ensure that the learning from this report informed the actions for Wales, in the development of a five year strategy for maternity services; Maternity Care in Wales: a five year vison for the future (2019-2024)[7].

In April 2017, under a new model for clinical supervision, the health boards took responsibility for the supervision of midwives practicing in Wales (previously undertaken by the Local Supervising Authority for Midwives). Since this change, there has not been a national overview of the delivery of midwifery supervision across Wales, therefore an independent review of maternity services is now timely.

The aim of our review has been to provide a national picture of the quality and safety of maternity services across Wales, to understand whether the care being provided is safe, and to identify wider learning to improve services for women and their families.

[5] https://gov.wales/sites/default/files/publications/2019-04/review-of-maternity-services-at-cwm-taf-health-board_0.pdf

[6] https://gov.wales/sites/default/files/publications/2019-04/nhs-wales-escalation-and-intervention-arrangements.pdf

[7] https://gov.wales/written-statement-publication-maternity-care-wales-5-year-vision-future

The types of maternity services available in Wales

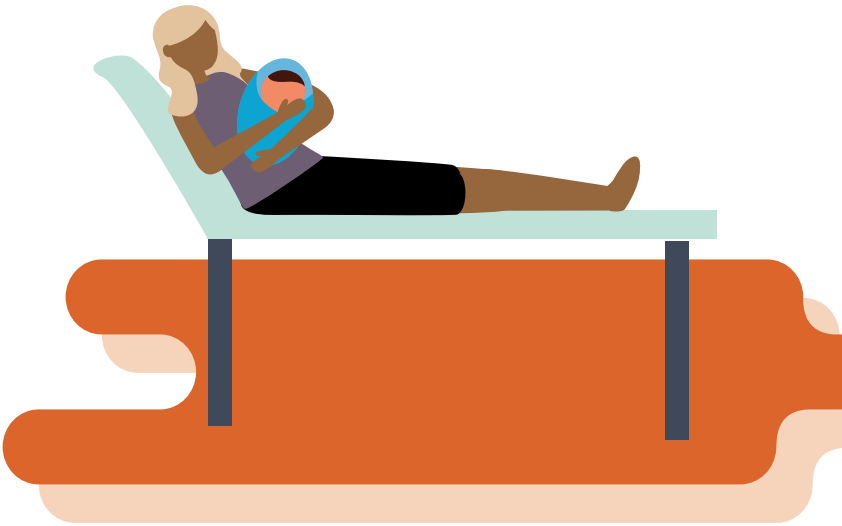
Maternity services across Wales are offered to all women and their families living within the geographical boundary of each health board. However, services may also be provided to women who reside outside of the geographical boundary, but who chose to birth in that health board's facilities.

The seven health boards in Wales are:

- Aneurin Bevan University Health Board[8] (Aneurin Bevan)
- Betsi Cadwaladr University Health Board[9] (Betsi Cadwaladr)
- Cardiff and Vale University Health Board[10] (Cardiff and Vale)
- Cwm Taf Morgannwg University Health Board[11] (Cwm Taf Morgannwg)
- Hywel Dda University Health Board[12] (Hywel Dda)
- Powys Teaching Health Board[13] (Powys)
- Swansea Bay University Health Board[14] (Swansea Bay).

Women who birth within Wales have the choice of birth setting as highlighted below (detail obtained from Your Birth – We Care (Heads of Midwifery Advisory Group (HOMAG), 2017[15]):

- Home birth within a familiar environment, with family present and care provided by midwives
- Freestanding midwifery-led units, providing similar care to that provided in a home environment by midwives, but in a freestanding clinical unit. These units are not always co-located near to a district general hospital
- Alongside midwifery-led units, based within the district general hospital site with care provided by midwives for healthy women, experiencing uncomplicated pregnancies
- Obstetric-led units, located within a district general hospital for women who need to be cared for (high-risk pregnancies[16]), or would like to be cared for by both obstetric consultants and midwives.



[8] http://www.wales.nhs.uk/sitesplus/866/home

[9] https://bcuhb.nhs.wales/

[10] http://www.cardiffandvaleuhb.wales.nhs.uk/home

[11] https://cwmtafmorgannwg.wales/

[12] https://hduhb.nhs.wales/

[13] http://www.powysthb.wales.nhs.uk/home

[14] https://sbuhb.nhs.wales/

[15] https://gov.wales/sites/default/files/publications/2019-03/your-birth-we-care.pdf

[16] A high-risk pregnancy is where a woman has one or more health concerns that increase her or her baby's chances for further health problems or a preterm (early) delivery.

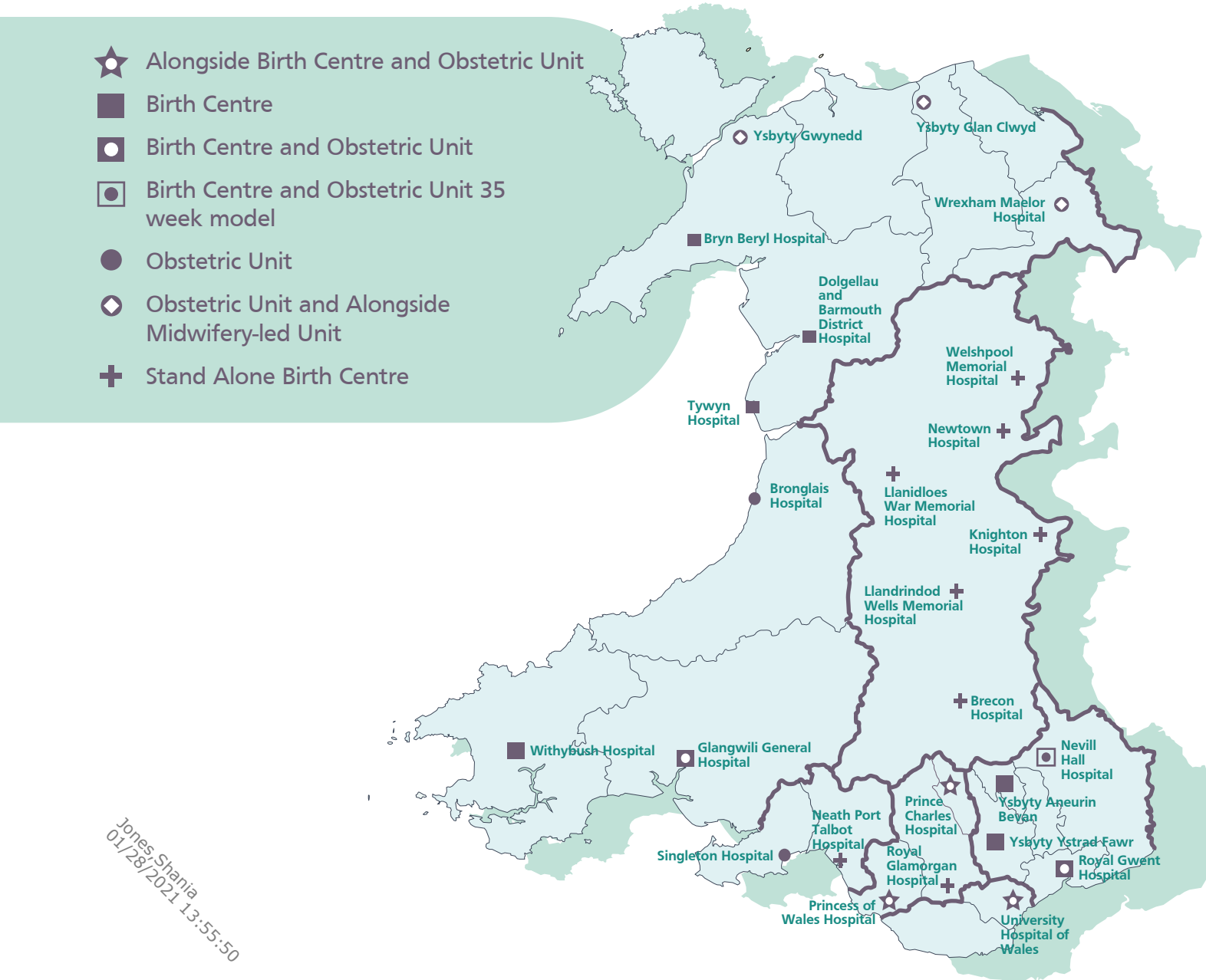
The map below details the location of each maternity service across Wales

Wales Maternity Units

University Health Board (UHB)
(1 April 2019)

Local Authority Boundary

- Alongside Birth Centre and Obstetric Unit
- Birth Centre
- Birth Centre and Obstetric Unit
- Birth Centre and Obstetric Unit 35 week model
- Obstetric Unit
- Obstetric Unit and Alongside Midwifery-led Unit
- Stand Alone Birth Centre



Did you know?

During 2019 across Wales...

14,513
baby girls were born

15,191
baby boys were born

861 were multiple births with
435 being boys &
426 being girls

Areas of Birth (% by Population)

19.3% born within the locality of Aneurin Bevan
(Population of 594,164)

19.5% born within the locality of Betsi Cadwaladr
(Population of 699,559)

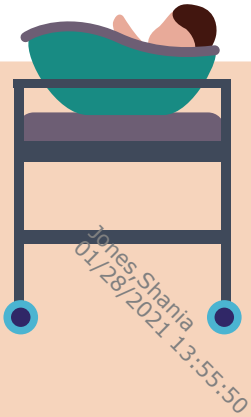
18.5% born within the locality of Cardiff and Vale
(Population of 500,490)

12.2% born within the locality of Cwm Taf Morgannwg
(Population of 448,639)

10.8% born within the locality of Hywel Dda
(Population of 387,284)

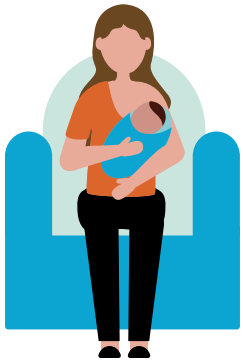
0.8% born within the locality of Powys
(Population of 132,435)

18.9% born within the locality of Swansea Bay
(Population of 390,308)



Types of Birth

63% were spontaneous delivery
14% were emergency C-section
13% were elective C-section
8% were forceps delivery
2% were ventouse delivery



63%
intended to breastfeed their babies

Data provided by Office of National Statistics (ONS) and North Wales Informatics Service (NWIS) 2019

What we did

The journey from early pregnancy to birth, and following birth, is a hugely important time for both mother and baby, and is often complex. In this first phase of our review, we examined the standard of care provided by each maternity service across Wales. We listened to the accounts of women, their partners and families, to understand their experience of using services before giving birth, and the support provided during and after the birth.

Focus of review

The purpose of our review was to understand how maternity services across Wales meet the needs of women and their families during their antenatal (before birth), intrapartum (labour) and postnatal (after the birth) stages of pregnancy. To accomplish this, we divided our national review into two phases. This report relates to the first phase, during which we explored the following main themes:

- **Quality of experience** – including overall experience, staying healthy, dignified care, timely care, individual care, information and communication and learning from feedback
- **Delivery of safe and effective care** – including managing risk, promoting health and safety, falls prevention, infection prevention and control, nutrition and hydration, medicines management, safeguarding, medical equipment use, quality improvement, research and innovation, information governance and record keeping
- **Quality of management and leadership** – including governance, leadership, accountability and workforce.

Throughout, we considered the following key questions:

- Is the care given well informed, individualised and family centred?
- Are women in Wales receiving safe and effective care?
- Are women receiving care from skilled multi-professional teams?
- Can the quality of services be sustained?
- How well are maternity service led and managed?

Scope and methodology

Phase One of our review explored the extent to which health boards across Wales:

- Provide safe and effective maternity services within acute hospitals and freestanding birth units
- Understand the strengths and areas for improvement within their maternity services.

As part of scoping our review, we engaged with other organisations who had recently conducted or planned to undertake further work in relation to maternity services, such as Welsh Government – Independent Maternity Services Oversight Panel[17] and Maternity Network Wales[18].

[17] https://gov.wales/independent-maternity-services-oversight-panel

[18] http://www.walesneonatalnetwork.wales.nhs.uk/maternity-services

We also worked with a range of stakeholders, including representatives from the Heads of Midwifery Advisory Group (HOMAG)[19], Community Health Councils (CHC)[20] and third sector organisations such as Mind Cymru[21]and National Society for the Prevention of Cruelty to Children (NSPCC) Cymru[22]. This helped us achieve our aim of engaging directly with women, their partners and families through the active promotion of a national survey, in order to understand their experiences of using maternity services.

Phase One

Phase One of our review took place between June 2019 and August 2020. The focus was on the quality of care provided in maternity units[23], up to the point of discharge, and included some aspects of antenatal care provided in the community. This consisted of:

- 15 unannounced inspections of maternity services within acute hospitals
- 10 announced inspections of free standing birth units
- A range of interviews with key leaders in each health board, including:
  - Chief Executive
  - Executive Director of Nursing
  - Medical Director
  - Chair.

Each individual inspection resulted in a report published on our website[24]. To supplement our fieldwork activity, we also carried out:

- A national survey of people using maternity services
- A national survey of staff working within maternity services
- A review of self-assessments completed by each health board.

[19] http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/HOMAG%20TOR.pdf

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

[21] https://www.mind.org.uk/about-us/mind-cymru/

[22] https://www.nspcc.org.uk/about-us/what-we-do/wales/

[23] Home from home units, free standing midwife led units, alongside midwife-led units and obstetric units.

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

Participation in the review

Stakeholder group

We established a stakeholder group to provide professional advice and support to inform the delivery of the review. The group also enabled us to engage with key organisations to share significant progress and key messages to the service throughout the review.

The stakeholder group representatives included:

- Community Health Councils Wales
- Director of Nursing representative
- General Medical Council
- Lay representatives
- National Institute of Health and Care Excellence (NICE)
- NHS Wales Delivery Unit
- NHS Wales Heads of Midwifery Advisory Group
- NHS Wales Maternity Network
- NHS Wales Neonatal Network
- NSPCC
- Neonatal Maternity Network
- Mind Cymru (Mental Health Charity)
- Public Health Wales
- Royal College of Anaesthetists
- Royal College of Midwives
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
- UK Nursing and Midwifery Council
- UK National Childbirth Trust
- Welsh Government.

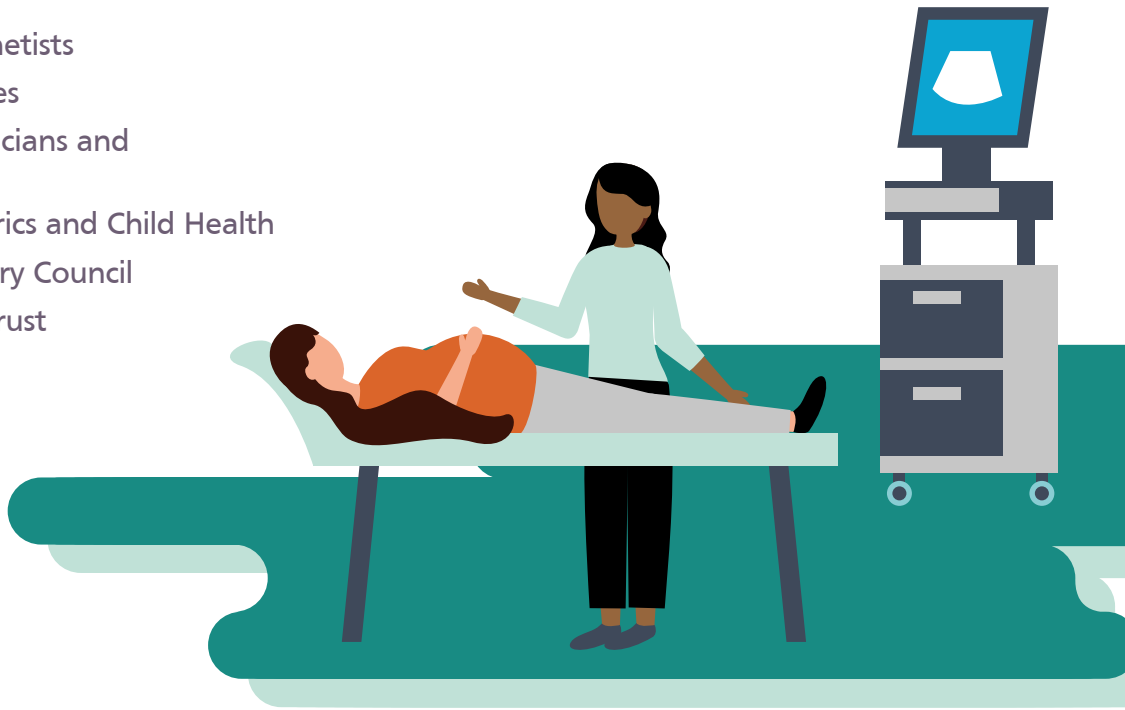
Advisory group

We also convened an advisory group in order to obtain expert professional views and opinions on specific maternity services topics, or issues that arose during the course of the review. The members had a diverse background within their specialty and had significant expert experience in maternity and/or obstetric care, and consisted of:

- Two professionals from the Obstetric specialty
- Two professionals from the Midwifery specialty
- Two professionals from the Anaesthetics specialty.

Document review

We completed an in-depth review of documents that we had requested, alongside a self-assessment that was sent to each health board, and considered local and national performance data and statistics.



National surveys

It was vital for us to gain an understanding of both public and staff views and opinions of maternity services across Wales. Whilst we captured and used the views of those using services, and those working within services on each individual inspection, we felt that this required specific attention. As such, we developed and launched two national surveys in order to gather a more detailed understanding of what people thought about maternity services.

Public survey

We launched a national survey in the autumn of 2019, which was developed in conjunction with the Community Health Councils. The survey enabled us to gather experiences from a broad range of women and their partners or families, who used maternity services across Wales. The survey questions covered experiences during pregnancy, birth (whether at home or in a maternity unit) and after the birth. We are very grateful for the assistance that the Community Health Councils provided in publicising this survey. As a consequence of this, and utilising our own social media channels, we received a considerable number of responses to this survey, containing rich information about the experiences of those who have used maternity services.

In order to ensure we captured and used this information effectively, we commissioned Wavehill[25] to undertake a detailed analysis of these responses. The report produced by Wavehill containing the full detailed results of the survey can be found on our website[26]. We have also released the data relating to the public survey in PowerBI format for people to be able to delve deeper into the responses. This can also be found on our website. At the earliest opportunity, and in advance of this report, we also shared with each health board some of the key themes emerging from the qualitative data from our survey. We did this in order to ensure that heads of service could use the information to inform their improvement agenda.

Staff survey

In parallel with the public survey, we also launched a national staff survey, to capture the views of staff working in maternity services. The survey covered patient care, professional development, health, safety and well-being and an overview of the organisation they worked within.

The results and findings from both surveys will be reflected throughout this report and the response data is detailed in the tables below.

Public survey response

We received 3,303 responses to our national survey from women and their families. The respondents represented all geographical areas of Wales, however, 20 responses were received from people living outside of Wales, or who did not provide sufficient information to determine their location. In addition to the national survey, we also received 122 completed patient experience questionnaires during our inspections. These were referenced within the individual inspection reports, which are available on our website.

[25] https://www.wavehill.com/

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

Public survey responses for each health board

Health Board	Number of Responses	Percentage of Responses	Percentage of Births
Aneurin Bevan	535	16%	21%
Betsi Cadwaladr	792	24%	20%
Cardiff and Vale	657	20%	18%
Cwm Taf Morgannwg	599	18%	11%
Hywel Dda	408	13%	11%
Powys	43	1%	2%
Swansea Bay	249	8%	8%
Total	**3,283**		

Staff survey response

We received 564 responses to our staff survey, with 71% of these completed by midwives. The remaining responses were received from consultants, healthcare support workers, administration staff, and those detailed as 'other'. Just over half the responses, at 57%, were from staff who had been working in their current role for more than five years.

Staff survey responses for each health board

Health Board	Number of Responses	Percentage of Responses	Staff Numbers[27]	Staff as % of National Total
Aneurin Bevan	90	16%	5,314	16%
Betsi Cadwaladr	113	20%	7,200	22%
Cardiff and Vale	76	13%	5,538	17%
Cwm Taf Morgannwg	57	10%	4,781	15%
Hywel Dda	87	15%	3,937	12%
Powys	52	9%	790	2%
Swansea Bay	89	16%	5,161	16%
Total	**564**		**32,721**	

[27] Staff numbers are taken from Stats Wales "Nursing, midwifery and health visiting staff" on 12 March 2020. Staff numbers shown are for September 2019 https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/NHS-Staff-Summary/nhsstaff-by-staffgroup-year

What we found

Is the care given well informed, individualised and family centred?

The Welsh Government's Maternity in Wales's Five Year Vision[28], sets an aim for maternity services across Wales to provide care to women, their babies and families based on their needs and decisions, where they have genuine choice, informed by unbiased information. Respectful care that is family centred allows women to have control over their treatment, enhances personalised care planning and informs choices available for the place of birth.

Women have the right to be involved in discussions and be fully informed about the care they receive, to allow them to make informed decisions about their care. Women are more likely to have positive experiences of childbirth regardless of the outcome, if their care is personalised, if they are treated with dignity and respect, and if they are fully involved in their care planning process.

Every women is different; some may be first time mothers, some may have experienced previous births which were positive and some may have had traumatic experiences. All women should feel empowered to be fully involved and able to make those important choices at a time that can shape lives.

[28] https://gov.wales/written-statement-publication-maternity-care-wales-5-year-vision-future

Communication

A number of the findings that we identified in relation to this area came under the general category of communication. We have broken this down below into the key elements that warrant attention.

What did people think about communication?

We found that most women and their families were extremely positive about the care and support that was available to them at all stages of their journey through maternity services. Our national survey noted that 84% of responses related to *'good care'*, where women said they felt *'cared for'*, '*listened to*' and *'supported'*, with 16% reporting mixed experiences.

Support with communication

Overall, we found that women were positive about their interactions with staff during their care. In relation to measures and systems to support good communication, we found that communication aids such as hearing loops, braille facilities or translation services were readily available if required, to benefit people with hearing, sight or language barriers.

For those who needed to communicate in the language of their choice, 76% of women told us that this was offered during their maternity care, which allowed for continued communication, regardless of barriers. However, this also means that nearly a quarter of all respondents were not able to communicate in their language of choice. Our inspections noted that information was available in both Welsh and English in all units, although content varied from setting to setting. However, we saw little evidence informing women how they can request information or support in other languages.

Being able to communicate effectively in the language of choice can have a significant and lasting impact on the women's experience of using maternity services, making them feel heard and listened to, during what can be an uncertain and frightening time. We believe more needs to be done to address this issue.

Birth plan choices

Both medical and midwifery staff told us that promotion of individual care and choices for women was a priority in care planning. However, only 68% of respondents to our public survey said their birth wishes had been listened to. Whilst this may suggest there were instances of women's choices being ignored, some responses may not have taken into account medical circumstances, which may have made it not possible to grant a woman's wishes in order to maintain the safety of the mother and baby. Across Wales, women's perception of choices being ignored was found to be higher during intrapartum care, rather than in antenatal and postnatal care.

In 2016, health boards across Wales adopted the 'Birth Place Decision' leaflet[29], which informs women of their options for birth place. Birth choice clinics and antenatal clinics operate in all health boards, to improve support for women and their families in making informed choices about their birth options. Whilst we found that water births were well promoted across Wales, in some units within Betsi Cadwaladr and Powys, access to water birthing pools was not always possible. This therefore limited the birth choice for some women in these areas.

[29] https://gov.wales/sites/default/files/publications/2019-03/your-birth-we-care.pdf

"Not able to offer choice of pool birth due to H&S risk with plumbing and financial restraints."

Views from staff who work in the service

To ensure the options highlighted are equally accessible to all women, we believe that water birth facilities should be available throughout all birth settings. Further work across Wales is required to ensure that this is prioritised to meet the birth choices of women.

Spiritual choices

Throughout Wales, all health boards provide a multi-faith chaplaincy service and within all acute hospitals a small chapel or multi-faith room was available for women and their families. We were also told by staff and women across Wales that arrangements or assistance was in place to enable women from different faiths to access the chapels or multi-faith rooms to meet their spiritual needs.

Partner or family involvement

We found that generally, a woman's partner or family was able to help provide support or assistance during their pregnancy journey, and could be involved with care in accordance with a women's wishes and preferences.

Open visiting was available in the majority of units, allowing the partner or a designated other to visit freely. However, our survey highlighted concerns that this arrangement was not always available across all health boards. This concern was also described by women and families as having a negative impact on their birthing experience, and is an area that we feel requires improvement.

"Partners were not allowed in the ward at night. My legs were numb. I couldn't get my bag for nappies, baby clothes, my pjs. I wasn't told until we got to the door of the ward. One of the most vulnerable times in my life and I should never have been left alone with a baby. All four mothers in the ward were awake all night. All were massively struggling. Their partners should've been allowed to stay. Preposterous that depending on what time of day you have your baby, is whether you are left alone to cope."

"Partner was made to leave every night during the induction process (we live an hour away). He was allowed to stay till 11pm. I gave birth at 10.30. It was scary and isolating sending my husband, who was my biggest support away. It also left him with very little chance of the initial bonding."

Views of women who accessed the service

Being listened to

A key theme to have emerged from our review, and in particular from our survey, related to concerns expressed by women of not being listened to during their care. In particular, there were frequent examples of women expressing they had not been listened to, or supported through the pre-delivery stage of labour, although they indicated they received excellent care from the delivery team. Only 2% of respondents across Wales highlighted they received care which exceeded their expectations during the birthing stage.

"We had a truly fantastic midwife who listened to my views. I had been advised to have an epidural as soon as I was induced, but this was not my wish. My midwife was fully supportive with this and ensured my birth went the way I wanted. The consultant was on hand to deliver twin 2 and he was brilliant through the whole delivery. On twin 2, he guided him in to place and talked to me about what was happening and kept me calm whilst the midwife delivered him. I felt supported in having a birth I wanted, thanks my brilliant midwife."

"There was a refusal from midwives to believe that I was in active labour, as when I went into hospital, I was not sufficiently dilated. They refused to give me any pain relief and I was left to labour in a little room for four hours. They would not re-examine me, and when they finally did, they realised I was 9.5cm and the baby was in the back to back position. I felt that given this was my second labour, that my first had only been five hours from the first contraction, and that I had a good understanding of how labour felt, they would have given more credence to my opinion on whether I was entitled to any Entonox."

"I was ignored a lot and unless you were one of the mothers making a giant fuss you received no help or support. Staffing levels were so low that I was often left alone crying with no pain relief or support after a c section looking after a new-born on my own. My partner was not allowed in as much as we would have liked and I desperately needed the help and emotional support."

Views of women who accessed the service

Consistent care

Despite positivity from women regarding their journey through maternity services, a further theme related to women raising concerns over the numerous different midwives or clinicians they saw throughout their care. Women expressed a view that having contact with a consistent number of the same individuals enhanced their continuity of care, and made it more personalised to them. Concern was raised around having to repeatedly recount medical history to numerous healthcare professionals for instance, with this being challenging for those recalling traumatic birthing or pregnancy experiences. Whilst we appreciate that it may be difficult to achieve at all times, there is undoubtedly a significant benefit in women receiving care from a smaller group of individuals, with whom they can build a relationship and receive more holistic and personalised care. This is something that all health boards should strive to achieve.

Single electronic patient record

There are possible benefits to the introduction of a single electronic patient record in addressing the issue of continuity of care. The introduction of this system is in the planning phase across Wales currently. It is widely felt that implementation of this system would improve the continuity of care, meaning women would not have to repeat their history or recent care and circumstances on numerous occasions, especially where trauma had previously been experienced.

"I saw a different community midwife at every appointment during my pregnancy so was unable to build up any set of relationship. Luckily my pregnancy was straightforward, but it meant I didn't feel like I could share or discuss any emotions or worries as she was basically a stranger every time."

"I had to go over the experience of giving birth every time a different midwife came to the house – which is traumatic after a difficult birth and emotionally jarring."

Views of women who accessed the service

Recommendations

All health boards should:

- Ensure that women are aware of how they can request information or support in their language of choice
- Ensure that wherever possible, women are able to communicate in their language of choice
- Consider how water birth options can be made available across all units
- Improve the ability of birth partners or family members, to be able to support women, in line with a woman's wishes
- Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care.

Recommendations

Welsh Government should:

- Ensure that the implementation of an electronic record is achieved as soon as possible.

Sharing experiences

Throughout our fieldwork, we identified some good examples of information sharing and opportunities for women and their families to share experiences of maternity services. This included information displayed to highlight who would be caring for the women and their families during their visit, notice boards highlighting information about a unit and its performance, engagement through social media, and health board surveys, for women and families to feedback about the services provided.

This included:

- **Who's Who Board** – staff information board which was useful in informing women and families who they would be likely to see within the units.
- **Notice boards for the benefit of women and their families** – detailing statistical data, compliance rates and key performance indicator data
- **Closed Facebook pages for the benefit of the women** – for sharing of information and a platform to share experiences
- **Friends and Family Test**[30] – introduced to allow for concerns, comments and good practice to be shared widely within the health board.

[30] Friends and Family Test is a questionnaire which Swansea Bay University Health Board have introduced to gain feedback, opinions and comments regarding the services, care received and improvements which could be made.

We found an example of noteworthy practice in Powys, known as Birth Reflections. This service is provided by midwives to allow women and their families to explore their birthing experiences, giving them an opportunity to gain clarity around any issues they may have encountered during the birth. Feedback obtained from women and their families allows suggestions to be made to services to improve the care and experiences of women and their families. The women we spoke with gave praise to the availability of this service.

Support, advice and guidance

Most women were satisfied with the amount of information, guidance and support that was available to them during their antenatal care across Wales. Examples of the type of support groups we saw included:

- Powys Mums Matter
- Breastfeeding Support Groups
- Yoga and Aqua Natal Classes
- Hypnobirthing
- Parent Craft Classes
- 36 Week Birth Choice Clinics.

For many pregnant women or new first-time mothers, the change in life can be substantial. Many women enjoy the experience, however, the journey can be challenging. By being part of a support group, such as those highlighted above, women and their families can talk to their peers and seek support from women who are in a similar situation.

Guidance from NICE[31] states that postnatal care should be holistic and individualised to a woman and her baby following on from birth, with the appropriate guidance and support provided. For the majority of women, the postnatal period ends between six to eight weeks after the birth, once they have received their postnatal check. Although, for some women, their postnatal care can be extended in order to meet any ongoing needs. However, the feedback we received from women about the support and guidance experienced during the postnatal phase was less positive than other phases of their pregnancy. We also found through our discussions with women that aftercare support is an area requiring improvement in after birth care in all health boards.

To ensure that a woman's care and support needs are met holistically throughout their postnatal phase of pregnancy, we recommend that each health board considers how it can obtain the opinion and experiences of women using their services. This will inform how it can improve the support and guidance required, to meet individual needs.

Promoting health and well-being

Our inspections found that the level of information available to women and their families for promoting health and well-being was appropriate and readily accessible. We saw plenty of literature advising women how to stay safe and healthy during and after pregnancy. Information in relation to self-care advice and support was displayed throughout units across Wales, informing women about the benefits of maintaining their health, and preparing them and their partners for parenthood. Overall, 64% of respondents to our public survey highlighted that they received a good level of information about their health and well-being, which included advice on healthy eating, the dangers of smoking, alcohol and drug use, and vaccinations during pregnancy.

[31] https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-use-of-nice-guidance/impact-of-our-guidance/niceimpact-maternity/ch2-maternity-and-mental-health

Smoking cessation

The majority of sites throughout our inspections adequately promoted smoking cessation. However, this was not replicated throughout all units, with Aneurin Bevan, Betsi Cadwaladr, Cwm Taf Morgannwg and Hywel Dda needing to improve in this regard. Our inspections noted that some units had established smoking cessation leads, who provide support and information to women to help them or their partners to stop smoking. However, these posts were not in place in all areas of the country. Further work with Public Health Wales[32] should be considered, to strengthen support in this area, to allow women and their families the best opportunity in achieving healthier lifestyles.

Promoting breastfeeding

It was positive to find during our review that breastfeeding was promoted throughout Wales, and staff highlighted that full support would be offered with breastfeeding when there were adequate numbers of staff on duty to allow for this. However, 10% of women responding to our survey said they had encountered negative experiences regarding breastfeeding support. This was in accordance with our findings during our inspections, where the service offered by breastfeeding support staff across the majority of Wales was compromised by high workloads, and the numbers of staff available. Health boards should consider how breastfeeding support can be improved and maintained at all times, for all women.

> "I was trying to breastfeed, and every midwife suggested and advised something different."
>
> "We were moved to a postnatal ward for 48 hours post birth due to my antidepressants. Multiple times I asked for help with breastfeeding and some of the midwives never came after saying they would. We were left to fend for ourselves. No one asked if I needed help in the shower. Had to nag for pain relief at times; especially after being promised it and people never came with it. […] No one was interested in how we were coping or my feelings."
>
> **Views of women who accessed the service**

[32] https://phw.nhs.wales/

Mental well-being and perinatal mental health support

It is highlighted by NICE[33] that women can develop mental ill health for the first time during pregnancy, and pre-existing mental health conditions can deteriorate in the perinatal period. Perinatal mental health problems affect up to 20% of women during pregnancy, or within the first year after giving birth. Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both[34]. In such cases, NICE guidance[35] recommends that women and their families need access to high quality, evidence-based care with discussions and on-going care planning taking place during all stages of pregnancy. This will allow for women and their families to receive the appropriate mental health support when required.

We saw that antenatal appointments in general made a specific attempt to discuss the changes in emotional well-being that can arise after the birth. However, from discussions with both women and staff we found concerns were raised about the perinatal mental health advice and support available during the earlier stages of pregnancy, where it was found to be limited. Within our patient survey, we also found concerns regarding the availability of postnatal mental health support.

"Overall I was not supported, [I] felt I was forgotten about often. I was very emotional and frightened on my first night, I called my mum and partner crying, midwives knew and nobody came to help. I had a post-dural puncture that went unnoticed for 2 days despite me telling them I had a headache."

"I struggled with breastfeeding and postnatal depression, the services for mothers for postnatal depression is lacking. I was in real need and there was no postnatal mental health care."

Views of women who accessed the service

[33] https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-use-of-nice-guidance/impact-of-our-guidance/niceimpact-maternity/ch2-maternity-and-mental-health

[34] https://www.nice.org.uk/guidance/cg192/resources/antenatal-and-postnatal-mental-health-clinical-management-and-service-guidance-pdf-35109869806789

[35] www.nice.org.uk/guidance/cg190

Our review identified that midwives across Wales are offered training in perinatal mental health, and are able to provide some support to women with mental health needs. They work collaboratively with adult mental health teams in each health board, to help ensure that care and advice is provided in a holistic way. However, staff we spoke with across Wales told us that the perinatal mental health support available to women required improvement and strengthening.

We found an example of noteworthy practice in Swansea Bay, where there is a joint working group in place, which consists of midwives, health visitors, social services and voluntary agencies, such as Surestart and Homestart (which are available through the Perinatal Response and Management Services (PRAMS))[36]. We found the PRAMS service leading the way in Wales, in treating and supporting pregnant women and new mothers who may be at risk of developing mental health problems. This is something that should be considered by all health boards, where it has not already been introduced.

Whilst the overall number of people who raised concerns with us about mental health support was low, it is clear that the adequacy of mental health support can have a significant and lasting impact on women who use maternity services. We believe that mental health support requires focus and improvement nationally, to ensure appropriate support is available in a timely manner during times of crisis. If left untreated, mental health issues can have significant effects on woman, their baby and the wider family.

Care during trauma or bereavement

A stillbirth or a death of a baby following the birth process can be hugely traumatic for both parents, as well as for other family members. During our review, we found that overall, each health board provided appropriate help and support in these tragic circumstances.

Our inspections found each maternity unit had dedicated bereavement rooms available for grieving parents and families, which offered a calm and peaceful environment.

Specialist bereavement midwives were in post in all health boards, and were very knowledgeable, supportive and approachable. Almost all staff we spoke with said they had received bereavement training and were confident in caring for any recently bereaved parents, and that guidelines, local policies and other support were available to enhance this. Midwives and maternity support workers highlighted in our staff survey that bereavement training was provided to a very high standard. This was consistent with our findings throughout our inspections. However, it was noted that access to timely bereavement training requires improvement.

Numerous bereavement support services are in place, to support women and families who have experienced a traumatic birth, or for those who want to question or gain further understanding about their birth experience. Women were also given the option of meeting with senior midwives to talk though their experiences and receive additional support and information. Each health board had its own bereavement support service in place for women and their families.

[36] http://www.wales.nhs.uk/news/12068

Recommendations

All health boards should:

- Consider the introduction of smoking cessation leads
- Consider working with Public Health Wales to further promote healthier living and lifestyles
- Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times
- Review the adequacy and availability of perinatal and postnatal mental health support for women
- Consider the introduction of PRAMS across its services
- Ensure that staff are able to access bereavement training in a timely manner.

Learning from women and their families

Feedback from those who have used services

A key element of ensuring that services improve, is listening to the experiences of those who have used them. We found that regular feedback is collected by all health boards from women and their families. The mechanisms for doing this range from the usage of comment cards and closed social media platforms to questionnaires or surveys, which encouraged both positive and constructive feedback, to help improve services. Within our public survey, the majority of women said they felt able to express their opinions and concerns with health boards, around their beliefs, emotions, language choice, home life and their overall health during pregnancy.

In our staff survey, 53% of respondents told us that although patient feedback is actively collected from women and their families and used to make improvements or changes in service delivery. Staff in the Hywel Dda and Aneurin Bevan had a more negative response on this issue. In addition, a theme emerged around the fact that women or families are not routinely being made aware of any actions or changes being implemented in response to their feedback. This is something that requires strengthening across all health boards.

Patient stories

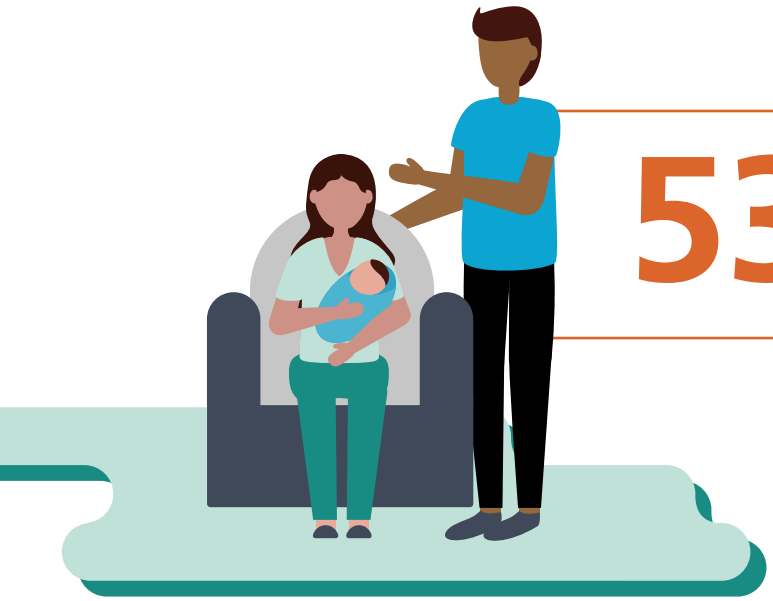
We learned that that whilst women's voices were heard at health board meetings through the presentation of patient stories, all health boards acknowledged that face to face sharing of experiences by women or families, to board meetings, or quality and safety committees was an area to improve upon. We feel this is an important issue as it ensures that leaders hear directly from people about their experience of using services, so that this can help influence and inform improvement. This can also be a positive way of achieving closure for women who have experienced poor care.

We did see some evidence of good initiatives enabling active listening to women and their families' experiences following birth. In Cwm Taf Morgannwg for example; Story Boards[37] were displayed across all units, and Maternity Conversation Cafés[38] were in use. Women and their families are invited to a café having used the health board's maternity services, to share their views and experiences with the health board and other families, on what is important to them, and how their experience can help shape the maternity services for the future. As a consequence, the health board reports that it has seen improvements in learning from its maternity service users over the last 17 months.

Recommendations

All health boards should:

- Consider what steps can be taken to ensure that learning from women's experiences can be improved, with a particular focus on sharing what has changed in response to feedback
- Consider strengthening arrangements for sharing patient stories at board and quality and safety committees.



53% of respondents told us that patient feedback is actively collected from women and their families and used to make improvements or changes in service delivery.

[37] http://cwmtafmorgannwg.wales/Docs/Integrated%20Medium%20Term%20Plans/IMTP%202017-20/IMTP%202017-20.pdf

[38] https://cwmtafmorgannwg.wales/maternity-conversation-cafes/

Are women in Wales receiving safe and effective care?

The health, safety and well-being of people should be a priority for maternity services, and people should be kept safe and protected from avoidable harm through appropriate care, treatment and support.

A service focused on safe care and support looks for ways to improve the quality of the service it delivers. Although the provision of care sometimes has an associated element of risk of harm, safe care will identify, prevent or minimise unnecessary or potential harm.

Maintaining quality and safety

Women and their families should receive safe and effective care throughout their pregnancy journey. The NICE[39] highlight that complexity in pregnancies has increased in recent years, and with this brings added pressures on staff and services to maintain effective and evidence based practice throughout. Quality and safety is everyone's responsibility, and should be prioritised in care planning and overall service provision.

To achieve safe and good quality care, there must be suitable processes and procedures in place, along with adherence to policy or guidance. Audit measures should be in place to monitor the safety and well-being of women and their babies, assessing risk throughout every step of the journey.

Key themes from our inspections

As we have noted previously, our overall view of the quality of services being provided within maternity units across Wales is very positive. We have no significant concerns over the delivery of care to women, and it is clear that the safety of women, babies and their families is a high priority for all health boards. As outlined earlier within the report, the results from our public survey are overwhelmingly positive and supportive of this view, with women and families pleased with how they were cared for.

An aim of this review is to ensure that health boards learn and improve from what we have found over the course of our work. As such it is pertinent to draw out some of the issues that we identified in order that each health board is aware and can learn from them.

[39] https://www.nice.org.uk/guidance/ng25/resources/preterm-labour-and-birth-pdf-1837333576645

Key themes requiring immediate improvement

Each of the following issues are matters that resulted in us issuing Immediate Assurance letters following some of our inspections. It is important to note that these issues were not present across all inspections and are not general theme. However, we feel it is relevant to highlight them in order that all health boards take note and learn from them.

Checking of neonatal resuscitaire and emergency equipment

One of the most common themes to have emerged from our programme of inspections was in relation to the adequacy of arrangements of checking neonatal resuscitaire and emergency equipment. This is a significant issue that resulted in 11 Immediate Assurance letters being issued following inspection. We found that mandatory checks on neonatal resuscitaire[40] units and other emergency medical equipment were inconsistently recorded in all health boards except for Powys. Consequently we could not be assured these checks were completed regularly and in line with health board policy, to maintain the safety of women and their babies.

This is an important issue to address, as the failure of this equipment in an emergency situation can have significant and adverse consequences. Since our inspections, health boards have provided us with assurance that these issues have been resolved. However, this remains an area that requires ongoing monitoring and audit to ensure that emergency equipment is checked in line with health board policy.

Medical assistance in emergencies

One of the key areas that we examined during our programme of inspections was the arrangements for accessing medical assistance in the event of an emergency. We found that in all units, all rooms had access to emergency buzzers and call bells to alert others in the event of an emergency, such as patient collapse. We also found that emergency equipment trollies, were well organised and contained all the required equipment, to support an emergency situation. The emergency drugs were also easily accessible to staff in emergencies, however, as highlighted above, safety checks of resuscitation equipment was inconsistent across Wales.

We also found in some units within Aneurin Bevan, Betsi Cadwaladr, Cwm Taf Morgannwg, Hywel Dda and Powys, inconsistencies in planning for emergency situations, emergency drills and the availability of policies and guidance for staff to ensure the correct processes are followed in the event of an emergency. These issues were raised following each inspection, and each health board has provided us with assurance through their action plans to confirm that these issues have been addressed and rectified. It is however, incumbent upon each health board to ensure that staff are fully aware of their roles, and the procedures to follow in the event of any emergency.

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

Birth pool evacuation

Within most health boards, staff told us that the choice of having a water birth is steadily increasing across Wales. Consequently, in order to maintain the safety of women and their babies, staff should be adequately trained in birth pool evacuation, and emergency evacuation equipment should be readily available in all relevant units.

Our programme of inspections found that emergency equipment was available in all units. However, we found in some units in Hywel Dda and Powys that staff were not adequately trained or following correct procedures in birth pool evacuation. These concerns were escalated during the inspections and the health boards have now provided assurance that training has been reviewed and received by staff, and suitable policies are being appropriately followed.

Security of newborn babies

Our inspections considered the security of newborn babies. We found various procedures and systems in place across Wales, to help keep babies safe and prevent the risk of abduction. These included systems for security tagging, cot security alarms and closed circuit television cameras. Although every unit had implemented security measures, we found that these arrangements were insufficient in a small number of units, and the risk of abduction remained.

Some examples of this included the entrance of a maternity unit where a camera was inadequately placed, prohibiting identification of people entering or exiting the department. In addition, on some units we found that ineffective door security allowed people to exit and enter a department without staff being aware. There were inconsistencies regarding abduction management across all health boards other than Powys, with poor compliance with abduction drills, or units not adhering to health board policies. Furthermore, we found risks associated with some cot alarms inactivated by parents or the easy removal of baby alarm tags.

To maintain the safety of babies, a consistent approach to this risk should be considered on an all-Wales basis, ensuring best practice is followed by each health board in using the most secure systems, policies and procedures.

Infection Prevention and Control (IPC)

We saw that IPC was of a high standard across the majority of units that we inspected. However, where modernisation and improvements in amenities were required, particularly for older buildings, compliance with IPC was not always to an acceptable standard. This was particularly an issue when it came to risks such as broken floor coverings (lino), carpets, fabric curtains and old wooden fixtures, fittings and furniture. We recommend that all units are reassessed and actions taken to ensure each environment is fit for purpose and fully compliant with IPC requirements, to maintain safety of staff, the women and their families.

We saw evidence of good compliance with IPC across the majority of units, and this was also confirmed by the staff we spoke with during our fieldwork. In the majority of health boards we saw good outcomes from IPC audits with follow-up work from IPC teams where necessary. However, in some units improvement was required to implement action plans following on from audits.

Hand hygiene

During our inspections we observed the majority of staff across all health professions adhering to the standards of being 'Bare Below the Elbow'[41]. However, some midwives were noted to be wearing jewellery, such as engagement rings, watches and false nails, which posed a risk to infection prevention and control.

We observed good hand hygiene techniques in all units, with hand hygiene facilities easily accessible to staff and women or visitors, and posters advertising the correct hand washing technique displayed. Hand hygiene gels were also readily available throughout all the units, to help minimise the risk of cross infection.

We also found that Personal Protective Equipment (PPE) was easily accessible and readily available, and staff confirmed that they were happy with the amount of PPE available to them.

Secure storage of chemicals

Many units that we inspected were noted to have unsecure storage for Control of Substances Hazardous to Health (COSHH)[42]. This posed a risk to the health and safety of women and visitors if unauthorised access was gained to these areas. Whilst most units were able to immediately rectify these issues during our inspections, we recommend that each unit regularly audits compliance in this area.

Equipment storage

The clinical areas in the majority of units we inspected were well organised, uncluttered, and clean and tidy. However, in a number of units, we found corridors were very much cluttered and being used to store large and bulky equipment or furniture. We found this was restricting safe movement and increasing the risk of trips and falls. In addition, these issues could impede safe evacuation in the event of an emergency, since furniture and other items were, in some instances, blocking fire exits.

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

[42] https://www.hse.gov.uk/coshh/

Recommendations

All health boards should:

- Ensure the ongoing monitoring in line with health board policy of neonatal resuscitaires and emergency medical equipment
- Ensure staff awareness of procedures and responsibilities to follow in the event of a medical emergency
- Ensure staff awareness of procedures and responsibilities to maintain the safety of the women using water birthing facilities
- Ensure that a clutter free and safe environment is maintained across units
- Ensure adequate infection control measures are in place, and adhered to
- Ensure the safe storage of COSHH substances at all times.

Recommendations

Welsh Government should:

- Consider the benefits of a consistent approach across Wales to prevent baby abduction.

Medicines management

During most inspections we found acceptable arrangements in place for the management of medicines, however, some improvement was required. These improvements are noted below. We found that midwives were appropriately trained to safely administer medication in line with the Nursing and Midwifery Council (NMC)[43] Code of Conduct and health board policy. Medication advice and pharmacy support was seen to be available along with health board policies which were in place, up to date and easily accessible.

Medication storage

We found in some units across Aneurin Bevan, Cardiff and Vale, Cwm Taf Morgannwg and Hywel Dda, that there were inconsistencies in the way temperatures were monitored and recorded for medication fridges, and fridges containing expressed breast milk.

It was apparent from our inspections that staff were not always clear on their role and the relevance of their tasks in respect of medicine management. For instance, some were unable to clearly explain why the information was recorded, and what they should do if the temperatures fell outside of manufacturer's recommendations. Staff within some units were also unable to locate the policy which would provide appropriate advice in this regard.

[43] https://www.nmc.org.uk/

Prescribing and administration

We reviewed the arrangements for the safe prescribing and administration of medication in all units inspected. Some inspections found issues regarding the prescribing and the administration of medication during labour, with particular concerns in Betsi Cadwaladr and Cwm Taf Morgannwg. Their processes being followed were not in line with the health board's policy, and some medication for the induction of labour was being administered outside of licence guidance. Whilst these concerns were dealt with and resolved under our Immediate Assurance process, this is an issue that all health boards should consider, to maintain the safety of women and their babies.

We also reviewed samples of patient records in each unit throughout our inspections and overall we found that drug charts had been completed in the correct and appropriate way. In addition, women were wearing identification bands to help ensure medication could be administered safely.

Pharmacy teams

Each unit across Wales had the support of dedicated ward pharmacists during the day. During periods such as nights and weekends, staff were able to obtain medication or advice from on-call pharmacy support teams or hospital site managers. We found that medication and pharmacy audit activity was of a good standard throughout Wales, with actions, improvements and active learning taking place when or if required.

Recommendations

All health boards should:

- Ensure that staff are aware of their responsibilities in relation to the safe storage of medication
- Ensure that the prescription and administration of medication for the induction of labour is done in line with health board policy.

Safeguarding children and adults

Across Wales, it was reassuring to see that policies and procedures were in place to promote and protect the welfare of children and adults who are vulnerable or at risk. Safeguarding training was mandatory, and 98% of staff who completed a HIW questionnaire told us they had received training within the past 12 months. In our staff survey, 78% of staff said they would know how to raise a safeguarding concern about a child or an adult who may be at risk.

Safeguarding teams

Throughout our review, we saw dedicated safeguarding teams supporting maternity services in each health board. The teams provided specialist safeguarding advice and support to staff and women when required. Women identified as having safeguarding needs were referred to receive dedicated care and support where required.

Specialist safeguarding knowledge

We found that the majority of midwives within each health board had received training, and developed specialist knowledge in variety of subjects that are associated with safeguarding, which included:

- Substance misuse
- Perinatal mental health
- Smoking
- Teenage pregnancy
- Domestic violence
- Asylum seekers
- Female Genital Mutilation (FGM)[44].

Within Cardiff and Vale, a specialist FGM clinic was held by staff from maternity services, and had been in operation for around 18 months. The clinic provided psychosexual therapy to women who had experienced FGM, with the aim of providing support, help and advice to aid recovery. We found this to be noteworthy practice, and ought to be considered in all areas of Wales.

Recommendations

All health boards should:

- Ensure women have access to Female Genital Mutilation clinics.

[44] https://www.nhs.uk/conditions/female-genital-mutilation-fgm/

Risk management

Effective risk management arrangements are necessary to ensure that the risk of harm associated with providing care is managed and minimised as much as is possible. Risks can be identified by staff, women or families using services, or as a consequence of incidents. Health boards must have in place robust reporting processes and measures to manage risks once they have been identified, in order to minimise their likelihood or impact. Furthermore, health boards need to demonstrate learning as a consequence of any adverse incidents or concerns, to ensure that staff and services provide safe and effective care, and risk of harm is reduced.

Risk management and incidents

Our inspections found that overall, units demonstrated clear and robust processes for reporting and investigating clinical incidents and concerns. We saw there were lead governance and risk midwives in post across all health boards, who held responsibility for reviewing, and clinical management of multidisciplinary investigations.

However, staff across Wales told us that learning and service improvements as a consequence of incidents or concerns, was not always actively shared with staff.

An impressive 90% of respondents to our staff survey told us that their organisation encourages them to report errors, near misses or incidents. This was further supported by our discussions with staff during our inspections. However, only 52% of staff we surveyed said that their organisation treats staff involved in incidents fairly. Moreover, a high number of staff whom we spoke to during inspection felt that incidents were dealt with in a punitive manner, with a blame culture evident. This is clearly an area of concern. If staff feel that incidents are not going to be managed in an open, and transparent way, it will serve as a deterrent to those wishing to raise concerns. Given the prevalence of this issue within the RCOG report of maternity services within Cwm Taf Morgannwg, this is an issue that health boards need to take seriously, doing all they can to promote a positive reporting culture amongst all staffing groups.

"Heavy handed approach to errors/incidents involving midwives. The unit encourages honesty and transparency but often hard on midwives involved. Doctors and midwives treated very differently following incidents."

"Sometimes feels as though midwives are blamed/punished when a clinical incident occurs yet the doctors are not put under the same stresses. It would be better if midwives and doctors involved were treated fairly and also discussed situation together."

Views from staff who work in the service

Investigating clinical incidents

Staff within the majority of health boards said they were given ample opportunity for non-clinical time, allowing them to review or investigate incidents appropriately, which may include root cause analysis methodology. However, we were told by staff in Aneurin Bevan and Swansea Bay that they did not always have time to investigate incidents properly. In addition, across all health boards, we were told that active learning does not always take place following investigations. This was highlighted to us by staff, who said little learning is shared or seen following incidents. Again, this is a significant matter of concern, and requires urgent attention and action from all health boards. If learning cannot be demonstrated following an incident or investigation, this can severely undermine confidence amongst staff in reporting incidents in future, and increase the likelihood of similar incidents occurring again.

Audit activity

In general we have found that audit activity is of a good standard. However, throughout our inspections, staff reported that they felt there were opportunities for better learning, and increased awareness of implementation of actions and improvements following audit activity. This chimes with the feedback we had from staff regarding learning from incidents, and we believe is an area that requires strengthening across all health boards to ensure that staff are fully aware of the outcome of audit activity, and ensure that effective sharing of learning takes place. We have made a series of recommendations around strengthening the breadth of audit activity.

Learning from external audit

National maternity audits are important methods for identifying improvements to services. One such audit is Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE[45]), which aims to identify what went wrong in pregnancy and why, so that care across the UK can be improved for all mothers and babies in the future. Similarly, Each Baby Counts (EBC[46]) is a national quality improvement programme introduced by the RCOG, to reduce, through data gathering and scrutiny, the number of babies who die or are left severely disabled as a result of incidents occurring during intrapartum care.

Our review has found that actions and recommendations emerging from national maternity audit, such as MBBRACE and EBC, are generally acted upon effectively by health boards. We also saw that annual external validation is received from national audit bodies such as MBBRACE and EBC, with ongoing work carried out by senior midwifery teams to ensure units are operating in line with the recommendations made. These relate to areas such as human factors and behaviour, workload and workforce challenges and communication. Progress against these recommendations was noted and this was seen to be consistent and well managed across Wales.

Single maternity dashboard across Wales

Dashboards are electronic tools that monitor the clinical performance and governance of each maternity service. They can help to identify patient safety issues and ensure timely and appropriate action can be taken, where required, to ensure high quality care. Data from the dashboards is presented to Welsh Government annually, who monitor performance of each health board.

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

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

Whilst we saw the active use of maternity dashboards in all units, due to different methods of capturing data, health boards are not currently able to review themselves against others and understand how they are performing. We are aware that work is underway to address this and introduce a single maternity dashboard. We believe this would be a positive development, enhancing the ability of health boards and Welsh Government to monitor performance locally, and nationally.

Recommendations

All health boards should:

- Ensure learning and service improvement actions are implemented following incidents, concerns or audit, is effectively shared with staff across all sites
- Ensure that steps are taken to encourage staff to speak up and report incidents without fear of reprisal or repercussion.

Recommendations

Welsh Government and the health boards should:

- Ensure the timely implementation of a single maternity dashboard across Wales.

Evidence based practice

Guidelines, policies and procedures

Staff within each maternity unit had access to their health board's intranet, and had an area dedicated to maternity services. Staff could access a wide range of midwifery, medical and clinical guidelines, and the health board's policies and procedures. However, our inspections found that many health boards had policies or standard operating procedures in place which had not been reviewed or updated in a timely manner and were therefore out of date.

Staff told us during inspections they felt there were issues with communication and a lack of consultation with teams when developing or implementing new policies and sharing this information. Our review has highlighted that all heath boards need to ensure that staff have access to the most up-to-date information, and are informed when documents are being updated. This is important because failure to do this can result in unsafe care being provided.

Recommendations

All health boards should:

- Ensure that policies and procedures are updated, ensuring staff are aware of updates to maintain the delivery of safe and effective care.

Are women receiving care from skilled multi-professional teams?

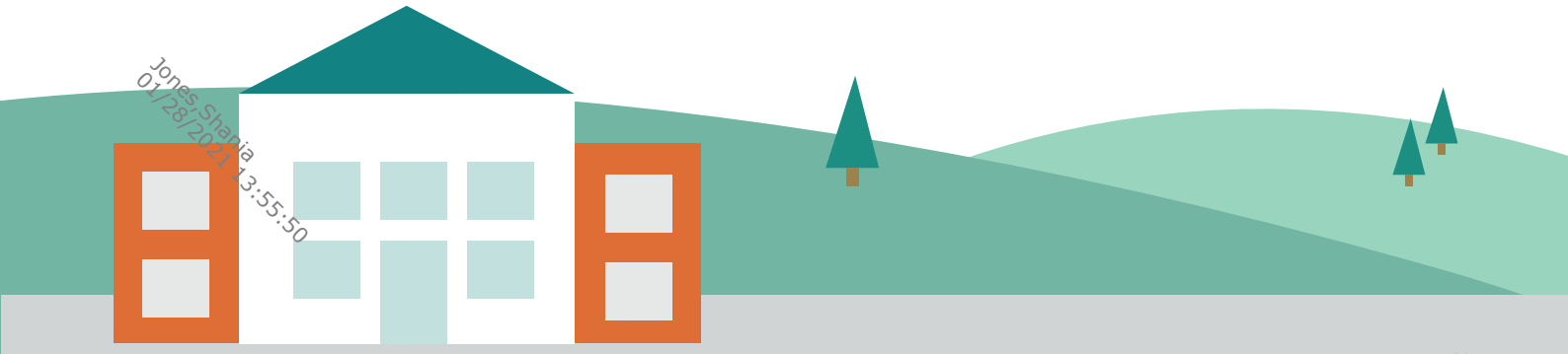
It is recognised by the RCOG and RCM that effective multi-professional working is a key component in the delivery of safe maternity care. Underpinning this is the importance of respectful team working to build a supportive workplace culture.

Multidisciplinary teams

Multidisciplinary teams within maternity services are a team of professionals from a range of different disciplines who co-ordinate and work together, to deliver comprehensive care to address a woman's needs in order to improve her and her baby's care and outcomes. Across Wales we consistently found teams working collaboratively within each maternity service, bringing together their expertise and skills to assess, plan and manage care. This was noted to improve health outcomes and enhanced satisfaction for women and their families.

Staff across all health boards told us that working relationships between consultants and midwives had not always run smoothly over previous years. However, they highlighted that improvements had been made more recently, resulting in effective team working. During our inspection programme, we found that relationships were strong and having an effective influence on the care of the women and their babies.

To ensure optimum functioning of the teams and effective outcomes for women and their babies, the roles of the multidisciplinary team members in care planning and delivery must be clearly negotiated and defined. We found this to be in place within all health boards and identified good examples of respect and trust with good use of skill mix. We also found jointly agreed processes were in place to maintain effective communication and interaction. Staff also told us that strong clinical and midwifery leadership helped to drive improvement in this area.



Multidisciplinary patient safety at a glance

Throughout our inspections, we saw multidisciplinary teams using Patient Safety at a Glance (PSAG) boards[47], on a daily basis. These boards clearly communicated patient safety issues and daily care requirements and plans, as well as individual support required and discharge arrangements. We found noteworthy practice within Betsi Cadwaladr's acute hospital sites, where a live camera link from the ward's PSAG board displayed information in handover rooms. This ensured the most up-to-date information was available for discussion during handover. Other health boards may wish to consider this initiative, to strengthen communication throughout teams, and allow for live up-to-date communication sharing.

Obstetric theatres

Obstetric theatre staff carry out surgical intervention for the safe delivery of babies through an assisted birth[48] or caesarean section[49], instead of a normal vaginal delivery. They ensure a safe and sterile field for this major abdominal surgery, for the safety of both mother and baby. To assist the obstetrician with surgery, a midwife will require specialist training. The majority of midwives we spoke with confirmed that unless they were trained to do so, they were not expected to undertake the role of a scrub nurse[50] and assist the obstetrician with the surgery.

Midwifery staff within Cwm Taf Morgannwg told us however, that on occasion they had been asked to assist in theatre and had not received appropriate training, or had their competencies signed off to safely perform scrub tasks and duties. This was identified also during our inspection of maternity services at the Royal Glamorgan Hospital in 2018, and was escalated at that time. Our findings during this review were raised with the health board during the inspection through our recommendations, and we have since received assurance that staff no longer practice in theatre unless appropriately trained. Nonetheless, we feel this is an issue that all health boards need to be aware of, putting measures in place to ensure that only those midwives who have completed an appropriate level of training are able to assist in theatre.

Recommendations

All health boards should:

- Consider the implementation of a live PSAG display feed, to enhance patient handover
- Ensure all midwives complete appropriate training before being required to assist in theatre.

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

[48] An assisted birth (also known as an instrumental delivery) is when forceps or a ventouse suction cap are used to help deliver the baby.

[49] A caesarean section, or C-section, is an operation to deliver your baby through a cut made in your abdomen and womb.

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

Research and innovation to improve practice

Midwifery and obstetric professionals should be committed to ensuring that care delivery is based on the best available evidence with research generating innovation in day to day practice. During our review, we explored the evidence-based care being provided within the maternity units, and through this we had multiple conversations with different staff groups across Wales.

We found that multidisciplinary teams had a good understanding of research and innovation, and that change was purposeful for the benefit of women and their babies. We were told that staff endeavour to provide women and their babies with the best care and services they can, and as previously highlighted, we found some good examples of this across Wales.

Each health board had a lead clinical research or improvement midwife in post. Their role is vital in undertaking research and enhancing patient care and experience through staff development.

We found some good examples of noteworthy innovations across Wales, to improve the care and services provided to women. These included the following:

- Babies Don't Bounce
- Birth choice clinics
- Epilepsy in pregnancy
- Growth assessment protocol – GROW – Gestation related optimal weight (GAP and GROW)[51]
- Learning through postpartum haemorrhage (PPH) (heavy bleeding from the vagina following childbirth).

The research and improvement midwives identify learning through a variety of sources, such as clinical incidents, complaints, training needs analyses or personal and professional development of staff. They share the learning not only through the development of care pathways and standard operating procedures across their maternity service, but by training and developing staff within the services.

Within Aneurin Bevan, we found that there were research and improvement champions in place to help ensure that this area was consistently highlighted within the local units. We were also told by staff across Wales that such roles would be introduced in all units in the near future. This role supports learning between the wider team of medical, midwifery and healthcare support staff. This was an example of noteworthy practice in encouraging and supporting innovative work and further research projects, and should be considered within all health boards across Wales.

Over the course of our review, we identified a number of innovative practices in place across Wales, which improved the safety of women and their babies and supported positive outcomes in the care given. These included:

Babies Don't Bounce

The Babies Don't Bounce[52] initiative has been established by Cardiff and Vale. This was in response to a number of incidents where babies had fallen out of cots and off beds within hospital units. Since its implementation, staff told us that they had seen a significant reduction in the incidence of babies falling or being dropped. We believe this to be an initiative that all health boards should consider learning from or adopting, to help reduce the risk of such incidents occurring.

[51] GAP and Grow - A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[52] https://gov.wales/sites/default/files/publications/2019-06/implementation-of-all-wales-intrapartum-fetal-surveillance-standards-for-maternity-services.pdf
http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Babies%20dont%20bounce%20poster%20barcodes.pdf

Birth choices

Birth choice clinics and antenatal appointments are held for women and their partners in all health board areas. These ensure consistent and appropriate advice and guidance is provided to prospective parents, in a balanced and unbiased manner to help with their pregnancy and labour or birth choices. The clinics have a positive impact on a woman and her family's experience and was noted to be good practice across Wales.

Cardiotocography (CTG)[53] monitoring

Within Cardiff and Vale, we found a live CTG viewing system had been implemented for staff within its labour ward. This system, along with midwives providing care for women, allows all maternity staff, to view and monitor the fetal heart rate electronically and remotely from outside of the individual delivery rooms throughout their care journey. We consider this system to be good practice and recommend that all health boards consider implementation of this this system.

Within our staff survey, 95% of respondents said they had received the appropriate CTG training within the last 12 months. We saw evidence to support this during our fieldwork and compliance was consistent across Wales. However, in some health boards we found inconsistencies in the way CTG is managed and reviewed, which may impact on the safety of women and their babies. We noted a tendency to review CTG traces in isolation, as opposed to at the bedside where the women and her entire clinical picture could be considered. We also found some inconsistencies in annotated CTG prints filed within health records and varied evidence of a 'fresh eyes' approach to CTG reviews. To ensure variations in practice are reduced and care is consistent, health boards must ensure CTG training and processes are in line with the All Wales Maternity Network 'All Wales Intrapartum Fetal Surveillance Standards[54]'.

Recommendations

All health boards should:

- Consider the implementation of champion midwives to support further innovation and research
- Consider the introduction of live stream CTG monitoring in all units.

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

[54] http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Babies%20dont%20bounce%20poster%20barcodes.pdf

Learning and development

Midwives and medical professionals are required to revalidate every three and five years respectively. Revalidation is the process by which professionals must complete a number of requirements set by their regulatory body to remain on the midwifery and medical register. In order to successfully complete this requirement, midwives and doctors must ensure their learning, training and development is comprehensive and up-to-date, along with regular appraisal processes.

Throughout our review, we found that staff were positive about the training available to them but stated that more timely access to initial training and updates would be beneficial. Overall, we found compliance with training was satisfactory to maintain safe care, although as highlighted earlier, improvement in accessibility to bereavement training is required throughout Wales.

Mandatory training compliance

Overall, we found robust processes in place to monitor staff attendance and compliance with mandatory training, such as health and safety, fire safety, infection prevention and control and safeguarding. Across Wales, this training was predominantly completed on-line and recorded centrally through an electronic staff record. We were told that both staff and managers receive prompts to inform them when staff required updates or refresher training. Training compliance was regularly monitored at a senior level, and any issues or discrepancies identified, were addressed with staff teams and escalated as required. Within our governance interviews, this was confirmed by the executive directors of nursing during our discussions, with examples provided to us on how this is managed locally across the units in Wales.

We found that each unit also held mandatory training specifically for midwives and obstetricians throughout the year. This included GAP and GROW[55], CTG and adult and neonatal resuscitation. However, we found that only 68% of staff in our survey had received this training. Some staff commented that this training would be beneficial to them, and women and their babies. We therefore recommend that all health boards review the access available to these training sessions, to ensure all relevant staff have timely opportunity to attend.

We also reviewed training records within each unit inspected, and discussed training opportunities with numerous staff. Through this we identified inconsistencies with compliance in timely training and/or updates. We found that the need to maintain safe levels of staffing in clinical settings often impacted on the ability of staff to attend training when required. Whilst units had allocated time for staff training, this was sometimes cancelled at short notice to prioritise clinical care.

Learning from postpartum haemorrhage

Postpartum haemorrhage (PPH), is the most common form of major obstetric haemorrhage. The RCOG suggests that between one and five women in every 100 experience PPH, and it is more likely to occur following a caesarean section birth.

Throughout our review, we found work had been undertaken across Wales in relation to the management of PPH (Maternity Care in Wales – A Five Year Vision for the Future 2019-2024)[56]. We found the work undertaken by all health boards, in line with the five year strategy, was positive, together with the ongoing plans in place to develop work to enhance the care and safety for women using maternity services across Wales.

[55] GAP and Grow – A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[56] https://gov.wales/written-statement-publication-maternity-care-wales-5-year-vision-future

90% of respondents to our staff survey said they had regularly received PROMPT training.

Practical Obstetric and Multi-Professional Training (PROMPT)

Each health board endorsed regular PROMPT training. This well-established course provides training for maternity staff and helps midwives, obstetricians, anaesthetists and other members of maternity teams to maintain safe practice, and to be more effective in the care they provide.

Almost 90% of respondents to our staff survey said they had regularly received PROMPT training, and that they found this to be excellent and very informative. Our conversations with staff throughout our fieldwork, largely supported this response.

Vaginal Birth after Caesarean Section[57] (VBAC)

We found effective implementation of the Vaginal Birth after Caesarean Section (VBAC) protocol. The VBAC process allows healthcare professionals to determine if a woman is able to choose between a repeat caesarean section and vaginal birth, following a previous caesarean section birth.

We found that women were engaged in the development of this service, and health boards had implemented training for VBAC. This has increased staff learning and development, is considered noteworthy practice, and will further develop the service across Wales.

Recommendations

All health boards should:

- Ensure that staff have timely access to the training that is required for them to carry out their roles effectively.

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

Continuous professional development

Appraisal compliance

During our discussions with them, staff told us that appraisals were an important part of their development. In our staff survey, 86% of respondents confirmed they had received an appraisal, or personal annual development review in the last 12 months. However, only 65% of these staff said that training, learning or development needs were identified during the appraisal process, which suggests scope for improvement in how appraisal systems operate throughout Wales.

Clinical supervision for midwives

In April 2017, under a new model for clinical supervision, health boards took responsibility for the supervision for midwives practising in Wales. Since this change, the delivery of midwifery supervision has operated at health board level rather than nationally.

Throughout our inspections, we reviewed the processes in place for clinical supervision. We spoke with clinical supervisors in all health boards about their role in providing support and professional supervision to registered midwives. There is a national target[58] to ensure supervisors meet with each midwife for four hours each year, and we found good compliance across Wales in achieving this target.

Induction and mentorship for midwives and medical staff

Overall, we found robust induction programmes in place for midwifery staff in all units, and staff advised these were of great benefit when commencing their role. However, induction programmes or packs were not consistently available in all units for new medical staff. During our inspections, we found that most units were in the process of addressing this.

We saw that ongoing training and mentorship for medical staff was in place, and staff we spoke with across all health boards said that the training, support and guidance was of a very high standard. However, we were also told by midwifery staff that the preceptorship programme[59] required some improvements to ensure new staff felt adequately trained and supported when newly registered.

Induction and preceptorship are important processes to integrate staff into their new roles. These allow for increased productivity, professional development and competent working when introduced at the right time, with the appropriate content and support available to all new staff.

Recommendations

Welsh Government should:

- Consider an all Wales approach to appraisals to ensure a consistent approach
- Consider a review of the preceptorship programme to improve the experience for newly qualified staff.

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

[59] https://www.nmc.org.uk/standards/guidance/preceptorship/

Can the quality of services be sustained?

Health boards should aim to consistently deliver high quality care. However, a key factor in sustaining quality of services is ensuring a strong workforce, who are skilled and trained to undertake their roles effectively.

Staffing, work and job plans

It is critically important for maternity services to have a workforce in place that is sufficient in both number and in capability. We found that there are risks around the ability of health boards to ensure that sufficient levels of staff are in place to enable the safe delivery of care at all times.

Birth Rate Plus

Birth Rate Plus[60] is a staffing methodology used in maternity services, based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period.

We found that overall, services were working in line with Birth Rate Plus. We were able to see that adequate staffing levels were were in place in all unit establishments across all health boards, and in line with Birth Rate Plus requirements. The NICE recommends that a Birth Rate Plus review is conducted at least every three years, and we found evidence that this was consistently carried out within all the services inspected. However, within our staff survey, only 40% said there are 'always' or 'usually' enough staff for them to do their job properly. This response varied considerably, with the health boards across south Wales having the most negative comments about staffing ratios.

40% said there are 'always' or 'usually' enough staff for them to do their job properly.

[60] https://www.rcm.org.uk/media/2367/birthrate-plus-what-it-is-and-why-you-should-be-using-it.pdf#:~:text=The%20Birthrate%20Plus%C2%AE%20methodology%20is%20based%20on%20an,pathway%20using%20NICE%20guidance%20and%20acknowledged%20best%20practice.

"The culture in the unit I work is awful, it's punitive, there is sadly lots of bullying and there is a huge blame culture. The senior management team are unsupportive and sometimes you feel like it's a witch hunt to pin blame on you. I feel scared to go to work in case I lose my pin as the staffing levels aren't safe and we aren't supported as midwives...."

"The safety of our patients and the care we give is always our main priority as midwives working out on the wards. There is a huge impact on the midwives and support workers due to staffing levels and lack of senior management support in our organisation."

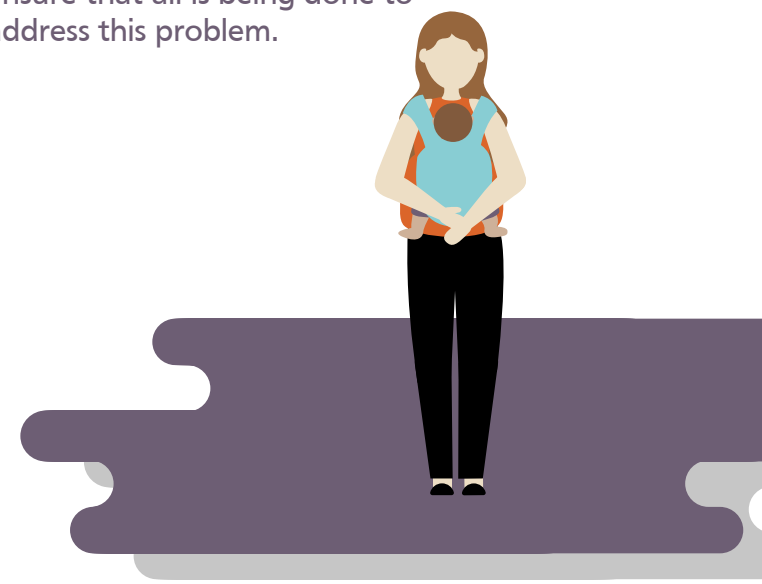
"Sometimes on shift I feel I am unable to give the care patients/babies deserve due to staffing and very busy ward. Also having to give ladies to other members of staff to look after whilst taking on elective section because of staffing, then having to return, look after a fresh section, complete deliveries on computer, as well as picking up with other patients I had to leave."

Views from staff who work in the service

Medical cover

A strong theme from our review is that staff perceive there to be a heavy reliance on the good will of doctors to cover shortages in the medical staffing rota. We saw evidence that during twilight shifts (between the hours of 2100 hours and 0200 hours), consultants would often undertake the role of a registrar in some health boards, to cover the deficit in registrar on-call duties. This was a concern due to compliance with the working time directive[61], and the amount of hours staff were actually working.

It was clear in our discussions with health boards that fragility of the medical staffing workforce is evident, although the executive and board team members we spoke with felt assured that this situation is being managed operationally on an ongoing basis. Continued monitoring of this situation and its sustainability is required to ensure that all is being done to address this problem.



[61] A law in which staff are not allowed to work more than 48 hours in a working week to maintain staff safety and well-being.

Staffing levels

During our inspections we reviewed the midwifery and medical rotas and establishments for each unit, and found they were comprehensively managed as highlighted above in relation to Birth Rate Plus. Where short or long term staff absences were identified across Wales, for example due to sickness, departmental escalation processes were in place to address the shortfall in staffing. The staff we spoke with were all aware of the local procedures on how to address and escalate such issues.

Throughout our review we found issues in many units, with staff from all disciplines working in excess of their contracted hours. This was to cover unfilled vacancies and unplanned absences.

As highlighted earlier, this also impacted on last minute cancellation of arranged training sessions. To maintain staff well-being, prevent fatigue and improve morale, health boards should monitor staff working hours locally, and review their current workforce plans. This should include a review of recruitment strategies to help address the current shortfall in staffing and cancellation of planned training within some units.

Where shortages were reported in acute hospital units, we were informed that some health boards temporarily deployed community midwives to cover the shortfall. Senior managers told us that they would also provide clinical cover when required.

> "Patient care and safety is always a priority for all staff and management."
>
> "When sufficient staff are on duty, I would generally be happy with the standard of care, but frequently there aren't enough staff, particularly on the postnatal ward and skill mix is sometimes an issue to demands of other areas of the unit."
>
> **Views from staff who work in the service**

Compliance with working time directives

Within a number of units across Wales, we found issues in relation to shortages in staff numbers as a result of vacancies or unplanned absences. Such shortages are not sustainable where there is a reliance on staff working in excess of their contracted hours, often not compliant with working time directives. In addition, this can have an effect on continuity of care if the use of temporary staffing was required. There is also a risk of care and patient safety being compromised as a result of fatigue, when staff are working excessively.

Some units did not monitor the number of hours individual staff members were working, and did not take steps to ensure staff had adequate rest time between shifts. In our staff survey, less than half the respondents agreed their job was good for their health, although the majority said their immediate manager took a positive interest in their health and well-being.

The issue of staff shortages, and staff working excessive hours is a concern across all health boards. Each unit should carefully monitor the hours its substantive staff are working throughout their health board. This is to ensure that patient safety and the quality of care can be maintained by reducing the risk of fatigue, along with maintaining staff well-being.

Recommendations

All health boards should:

- Review their workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups.

Maintaining staff morale

Celebrating staff success

Celebration of staff achievements, good work or general care and kindness can promote more success, and will add to the satisfaction of staff in the workplace, as well as that of women and their families. During our fieldwork, we noted a number of good initiatives across Wales to recognise and commend good practice and care within units. Some examples we found during our inspections include the following:

- Kindness boards displayed in staff areas
- Greatix electronic database for recording of good practice/care
- Caring for you Campaign[62] (improving the health, safety and well-being of members in their workplaces)
- Employee of the month
- Feedback Friday cards
- Letters from supervisors highlighting areas of good practice
- Recognition awards for volunteers.

These were positive initiatives and all health boards should consider introducing some or all of them in their maternity units.

Recommendations

All health boards should:

- Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams.

[62] https://www.rcm.org.uk/supporting/getting-help/caring-for-you/

How well are maternity services led and managed?

Strong leadership and management is essential to the delivery of safe, and effective care. Well-led and well-managed services contribute to safer, and more effective care for those using the services. The better a maternity unit is run, the more positive the experience is for women and their families. When issues are identified relating to poor care, whether these are individual concerns or systematic issues, it is often the case that these matters are rooted in poor leadership, management or governance arrangements.

Leadership

The effectiveness of how maternity services are led and managed, has a significant bearing on the overall quality of care provided, and consequently upon the experience of those using the services. Overall, we have seen services and units led by a hugely committed workforce, striving to provide the best level of care, and provide a positive experience for women and families. As our public survey has demonstrated, the majority of women were pleased with the level of care and support that they received at each stage of their pregnancy.

Our programme of inspections have nonetheless highlighted some concerns over the effectiveness of the management of the maternity units. It has been striking to note how consistently we identified patient safety issues, which gave rise to concerns over local management and governance arrangements of these units. It is clear that there is room for improvement, to ensure that safe and effective care is being provided consistently across Wales.

Executive and board leadership

Our review has considered the findings from our inspections, document analysis, surveys and discussion with key leaders of health boards. Overall, we have found executive and board leadership across Wales to be good. Through review of the minutes and actions from executive meetings, where audit and governance responsibilities are addressed and monitored, we concluded that there is clear oversight of maternity services.

During our governance interviews, the executive and board members told us that they take the opportunity to visit maternity units to meet with staff, women and their families. During our fieldwork, this was confirmed by staff, the majority of which were well aware of the senior management teams and executive team members for their directorates and health board. We were also assured that where improvements were needed, good relationships have been fostered with the maternity service teams, which allow for effective communication to take place. This was confirmed by the teams during our inspection programme.

Senior leadership

Our review has found medical leadership throughout Wales to be effective, supportive and focused on the care being given to women and staff well-being. We found a number of good examples of successful medical leadership, and this was also confirmed through the discussions we held in our governance interviews with executive Medical Director's across Wales. Staff also told us throughout our inspection programme that support and engagement from medical staff and the clinical director to be very positive.

Senior midwives and ward managers were also seen to play a vital part in management and leadership or maternity services, with their main focus being on patient care and staff well-being. During our inspections, most staff told us that they felt fully supported by their direct leaders, with some comments received in our staff survey stating they felt their manager can be counted upon. However, we also received some negative feedback during interviews, suggesting a perceived lack of effective communication and engagement with more senior staff, which was noted to have a detrimental effect on working relationships.

"I have been very impressed with the level of personal support provided, especially with respect to serious incidents at work. Having previously worked in England, I was astonished to see the difference and how in Wales the staff care for each other and support each other."

Views from staff who work in the service

We saw good examples of work undertaken by consultant midwifes to facilitate and achieve expert clinical practice, provide leadership and management support, undertake education and practice development research and implementing service improvements. This included the development of the new VBAC protocol mentioned in an earlier section, increased user engagement in service development and producing and implementing numerous training programmes to develop the knowledge and skills of staff. These posts were in place in each health board and are key to the further development of maternity services across Wales.

"Excellent line manager – fosters a culture of openness and team work. Supportive and encouraging."

"I have had full support and encouragement from my manager (matron). She has always been positive with my practise and CPD and makes me feel valued."

"My immediate manager works in an office adjacent to the staff office and always has an open door policy. She is approachable and always happy to help out in a clinical way as well as managerial."

"Ward managers show very little concern for staff well-being. They are only concerned with their office work – never cover staff for meal breaks or help on wards voluntarily, often can't be found on the wards."

Views from staff who work in the service

Unit leadership

We found that most units across Wales were well led and had good governance processes in place. However, it is clear from the sheer number of consistent patient safety issues to have emerged from our programme of inspection, that there is room to strengthen these arrangements. For instance, our inspections identified that the governance processes and leadership of the free-standing birth units of Betsi Cadwaladr required improvement due to a lack of oversight on key areas such as audit, checking of medical equipment and IPC. As highlighted earlier in the report, we consistently uncovered issues regarding the checking of emergency equipment in line with health board policies. These issues are not down to individual failures, rather they represent a need to strengthen certain aspects of management and governance of these units to ensure that all measures are taken to ensure the safety of those using the services.

During our inspections, governance interviews and from the completed executive team self-assessments, we found that good governance processes were in place in most units. However, where we identified issues locally as highlighted above, we have received assurance through our Immediate Assurance process and inspection recommendation action plans that improvements have been made or are in progress. This was also confirmed during our governance interviews with executives and board members, who felt such improvements were being prioritised as a result of strong and committed heads of midwifery and medical leads, along with senior midwifery teams, who strive to lead dedicated and hardworking staff teams.

Throughout our inspections, most staff reported that leadership within the units was excellent with leaders being involved in clinical practice when required. However, some of the comments received within our survey suggested that staff felt senior manager visibility could be improved, due to their office location being away from the units. Senior staff we spoke with confirmed that they addressed this by frequently attending the units. Whilst some clinical staff confirmed this, others felt this could further be improved in some units, which would allow for stronger working relationships.

"I know all of the senior managers on the unit, but I am unsure if they know their staff. There is very poor communication between senior management and staff and senior management are very rarely visible during the day."

"I know what they do and how they cascade information, but a general member of staff may not even know what they look like, as they rarely walk the floor to see staff and patients."

"I know managers' names and faces, but senior managers have made no effort to get to know staff or the daily workings of the unit. With the exception of the (manager) who is always supportive, visible and available to contact, the other senior managers are invisible. On several occasions when managers on call have been contacted, they don't answer their phone out of office hours."

Views from staff who work in the service

Culture of maternity services

Culture is an incredibly powerful force, and can be simply described as 'how we do things around here'. A negative culture can have a significant and detrimental impact upon the quality and safety of care, and most significantly can pose a real risk to outcomes for women and babies. Conversely, a positive and open culture can contribute to effective and safe care being delivered, with women and families having a positive experience of using the service.

Generally, across all of our inspections we found the culture to be positive. It was often described to us that the teams were more 'like a family', with positive working relationships witnessed by us. This was supported by the responses in our staff survey, with a majority feeling there is a culture of openness and learning that supports staff to identify and solve problems.

Organisation's priorities

Throughout our review and inspections we have seen staff who are compassionate, committed and keen to promote the work they do. This was not only supported by comments received from women and their families, it was also seen in the staff survey results, where 84% agreed that the care of women and their families is the organisation's main priority. This positive result was common across all health boards.

However, 16% of survey responses were more negative regarding this issue. Responses were more negative from staff working within Cardiff and Vale, Cwm Taf Morgannwg and Hywel Dda, where inadequate staffing levels and poor communication from management teams were highlighted as having a detrimental effect on individual and personalised care given.

"Any feedback we receive is mostly negative. There is a blame culture within our organisation and it appears that some senior members of the team thrive on putting staff down."

"The Trust does take near misses/incidents very seriously but I feel there is very little support afterwards for staff involved. Also poor feedback."

"Lack of support for staff from management, culture of blame towards midwives and concerns raised are often dismissed by upper management."

Views from staff who work in the service

Quality governance systems and processes

Effective quality governance is a requirement to support the safe delivery of care. Health boards must have in place systems and processes that allow them to monitor their services, identify issues at the earliest possible moment, and learn from them.

Audit

We saw that each maternity service regularly monitors the quality of care being delivered through their quality governance processes. This was done mainly through audit activity, and key meetings, such as quality and safety, infection, prevention and control meetings and clinical incident reviews. In addition, we saw evidence that there were regular departmental meetings, which included; ultrasound screening, labour ward activity, postnatal and neonatal forums and weekly multidisciplinary team meetings.

Record keeping

Throughout our fieldwork, we considered the arrangements for patient confidentiality and compliance with Information Governance and General Data Protection Regulations (GDPR) 2018. In all health boards other than Powys, we found patient information was not always being managed or stored securely, to maintain patient confidentiality. This included unlocked cupboards, notes trolleys, and doors left open to areas containing multiple patient records. These issues were dealt with under our Immediate Assurance process and we have since received assurance from the relevant health boards, through improvement plans.

Across Wales we generally found an acceptable standard of documentation throughout the multidisciplinary teams. However, across all health boards, we found some examples of patient records being disorganised and difficult to navigate. Improvements were required to rectify this issue, to prevent any adverse outcomes in the delivery of care.

Risk assessment, clinical incident reporting and lessons learned

Across our inspections we found, in general, that risk assessments and risk registers were completed and maintained, and were updated regularly. We saw that risk mitigations were actioned throughout. We also found during our governance work that executive teams and boards monitored higher risks regularly, with each health board holding monthly governance meetings which considered risks and clinical incidents. Through these meetings, any trends or themes are identified, and any actions allocated to teams to address areas requiring improvement.

Through our discussions, we were informed that lessons learned following incidents within maternity units were shared and circulated to staff throughout all units within a monthly newsletter. However, although we saw evidence of this on staff notice boards, staff we spoke to during our inspections stated that often they did not see this communication. It is clear that health boards need to identify more effective or additional mechanisms for sharing this information.

We did not identify any concerns regarding under reporting of clinical incidents in any health board. However, as noted earlier in the report, and where we made a recommendation, there is significant room for improvement for all health boards in ensuring that trends and themes arising from incidents are effectively shared with staff in order to improve quality of care.

Learning from independent review

In response to the RCOG and RCM independent review of maternity services at the former Cwm Taf University Health Board, and the publication of the report in April 2019, the Minister for Health and Social Services required all health boards to consider their own maternity services. Health boards were asked to consider the recommendations within the report, and provide rapid assurance to Welsh Government in this regard.

We discussed with multiple staff from all grades and disciplines throughout our review, the learning that has taken place since publication of the report. We explored how each health board considered the findings of the report and the recommendations within it. We found that each health board's aim was to address any issues identified and to become confident that the concerns raised in the report were not present within its maternity services. Where improvements were identified, plans were immediately made and actions implemented to address the issues.

We saw across all health boards that action planning had taken place following the independent review, with improvements implemented in line with the recommendations made. We found where issues identified could not be addressed immediately, action plans were in place with appropriate timescales to address these. We saw evidence that actions and progress for improvement were regularly discussed within services across Wales, and also within the HOMAG meetings.

Recommendations

All health boards should:

- Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved.

Conclusion

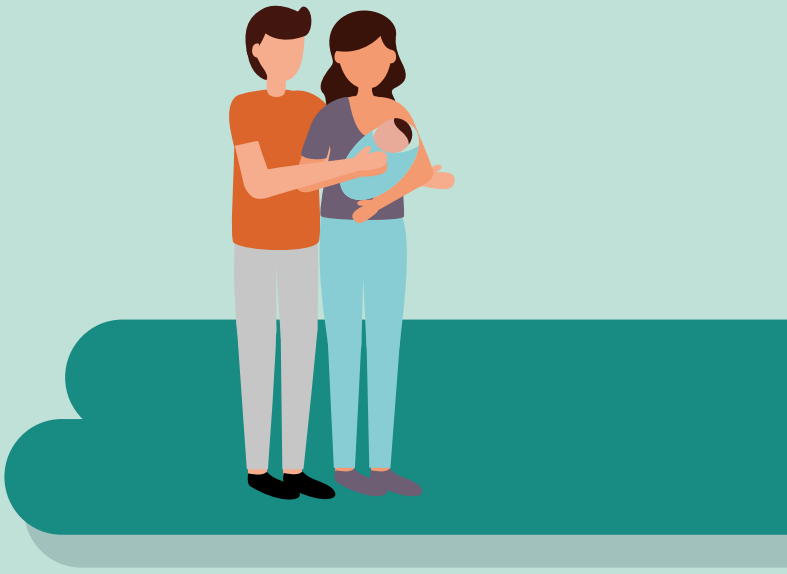
This report highlights the key themes and findings from the first phase of our national review, with Phase Two due to commence in late 2020. It is clear from our findings to date that the quality of care that is being provided across Wales is generally good, and that the majority of women and families who use maternity services report positive experiences, delivered by a hugely committed and dedicated group of professionals.

Nonetheless, there are some clear messages for heads of service to note. In particular, more needs to be done to ensure that women are heard and listened to. The arrangements for the safe and effective management of maternity units requires improvement, as does ensuring the presence of an open and transparent reporting culture demonstrating effective learning.

It has been a challenge to undertake this review due to the scale of activity required against a backdrop of the RCOG report regarding the former Cwm Taf Health Board. The report undoubtedly caused repercussions for all maternity services across Wales, and as a consequence we have striven to build positive relationships with all stakeholders, to ensure that services understood why, and how we were to undertake our review.

This has culminated in a positive relationships being built with all stakeholders throughout this review. It is clear that there is a strong will amongst both those working in, and those leading services, to continually improve the standard of care being provided. Each individual inspection has seen health boards respond positively to the issues raised, and we have been assured that relevant improvements have already been made as a consequence of our work.

We are confident therefore that the findings and recommendations from Phase One of our review will also be acted upon, improving the experiences of women and families on their journey along the maternity pathway.



What next?

We expect all health boards across Wales to carefully consider the findings from this review and our recommendations set out in Appendix C.

We hope that this information will be used to further improve services being provided to women, and to inform further work across Wales, as highlighted within the report. Welsh Government recommendations are also detailed within Appendix D for consideration.

Three months after the publication of this report, each health board and Welsh Government, will be required to submit an improvement plan in response to the recommendations. This is to ensure that the matters raised by our review are being addressed.

As previously mentioned, the findings within the review so far have enabled us to review the scope and direction of Phase Two. Detail regarding what Phase Two will include can be found in Appendix A.

Appendix A – Phase Two

Phase Two (November 2020 to spring 2021 – subject to change)

Further planned activity

Phase One of the review identified some issues in relation to aspects of maternity care that were outside the original scope of the national review. Consequently, we feel there is value in focusing our attention on developing a further understanding of these specific issues during Phase Two. These key areas to focus upon relate to:

- Antenatal care – to consider the quality of care provided by community midwifery teams
- Postnatal care – to consider the periods after the birth and up to the stage of health visitor engagement
- Follow-up on some of the inspections undertaken as part of Phase One, to understand what progress is being made.

Phase Two will seek again to explore in relation to the above:

- The experiences of women, their partners and families.

It will also explore the extent to which health boards across Wales:

- Provide safe and effective maternity services
- Understand the strengths and areas for improvement within their community maternity services.

Approach and methodology

The antenatal and postnatal periods during pregnancy and following the birth are important times for both the mother and the baby, and at times can be complex. For Phase Two, we will gather intelligence and review antenatal and postnatal services across Wales.

We will listen to the accounts of women, their partners and families to gain further insight, and understand their experience of using services.

To inform Phase Two, we will review the information and evidence obtained through our work to date. In addition, follow-up assurance work will be undertaken for a selection of inspections undertaken during Phase One of our review, in order to determine completion or progress of actions in line with recommendations made during inspection. To obtain this assurance, we may be required to undertake some onsite follow-up inspection activity. Decisions to undertake these inspections will be subject to risk assessment and intelligence, in view of the current COVID-19 pandemic.

In undertaking Phase Two, we will consider:

- A range of information and data regarding antenatal and postnatal maternity services across Wales, including any concerns intelligence held by HIW and Welsh Government
- Information provided by each health board regarding community maternity services
- Evidence obtained during Phase One fieldwork, along with both public and staff surveys
- Information obtained through various data collection methods, including attending antenatal and postnatal classes and holding focus groups on themes such as antenatal classes, breast feeding support groups and mother and baby groups.

Working with others

HIW will continue to work with a range of stakeholders, including the Community Health Councils and third sector organisations, in order to engage with women, their partners and families to understand their experiences of maternity services across the communities of Wales.

HIW will liaise with these stakeholders at key intervals throughout the review to share plans and ensure any joint working opportunities are explored to avoid unnecessary duplication of efforts and to share findings following completion of fieldwork.

Planning and timescales

It is our intention at this stage to conduct Phase Two of the national review between November 2020 and March 2021, with a view to reporting our findings by summer 2021. We are aware that these timescales may be contingent upon the impact of the COVID-19 pandemic, and winter pressures.

Reporting

We hope to produce a final National Maternity Review report by summer 2021. This will be a single report capturing the findings of Phase Two, and progress made by services since Phase One.

A dedicated webpage for the maternity review will continue to be found on HIW's website, sharing updates on the key findings from the review. Following publication of the Phase One national report, follow-up activity will be considered and a Welsh Government learning event will also take place in December 2020.

Out of scope

We have noted a number of areas during the national review which may warrant further examination in the future. However, it is not possible to include them within the scope of this review:

- Obstetric theatre environment, procedures and pre-assessment
- Neonatal care.

Appendix B – Glossary of terms

Anaesthetist	Doctor who specialises in giving anaesthetic
Antenatal	Term that means 'before birth'
Birth choice	Decision on birthing method in line with the services available for individualised care
Caesarean section delivery	Surgical procedure in which a baby is delivered through a cut in the abdomen and uterus (also called a 'C-section')
Entonox	A gas which is inhaled to help reduce pain
Epidural	An injection in your back to stop you feeling pain in part of your body
Fieldwork	Refers to the period when maternity unit inspections were undertaken
Forceps delivery	Forceps are smooth, curved metal instruments that look like large tongs. They're placed around the baby's head to help in delivery
Gynaecologist	Doctor who has undertaken specialist training in women's health
Haemorrhage	Excessive bleeding
Home birth	Labour and delivery that takes place at home, under the supervision of a midwife
Hypnobirthing	A complete antenatal programme focussing on a combination of education, self-hypnosis and deep relaxation to help achieve a more comfortable birth
Intrapartum	Term meaning childbirth or delivery
Labour	Process a woman's body goes through when her baby is born
Midwife	A person who has been specially trained to care for women during pregnancy, labour, birth and after the birth

Multi-faith room	A multi-faith room is a quiet location within busy environments such as hospitals where people of differing religious beliefs, or none at all, are able to spend quiet time
Neonatal resuscitaire	A medical devise to have on standby during labour and delivery procedures. Combining effective warming therapy with components needed for clinical emergency and resuscitation of babies
Obstetrician	A doctor who has undertaken specialist training in pregnancy and childbirth
Perinatal	Period before and after birth. The perinatal period, starting the 20th to 28th week of gestation and ends between the 1st and 4th week after birth
Perinatal and postnatal mental health	Condition that affects some women in early pregnancy, early days following birth and weeks or months after giving birth
Post-dural puncture	Post-dural puncture headache is a complication of puncture of the dura mater, one of the membranes around the spinal cord. A common side effect of lumber puncture and spinal anesthesia
Postnatal	Term meaning after the birth
Postpartum haemorrhage	When a woman loses more than 500 ml of blood after birth
Spontaneous delivery	A vaginal delivery that happens on its own, without requiring doctors to use tools to help deliver the baby
Theatre	An operating room in a hospital or other health facility
Vaginal Birth after Caesarean (VBAC)	When a woman has a vaginal birth after having had one or more previous caesarean sections
Venous Thromboembolism (VTE)	Term referring to blood clots in veins, an under diagnosed and serious, yet preventable medical condition that can cause disability and death
Ventouse delivery	A procedure were a vacuum cup is attached to the baby's head by suction to aid in delivery
Water birth	Where a baby is born fully submerged in water.

Appendix C – Health board recommendations

As a result of the findings from this review, we have identified the following recommendations in the table below. Where applicable, the health boards should:

Recommendation		
1. Ensure that women are aware of how they can request information or support in their language of choice.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
2. Ensure that wherever possible, women are able to communicate in their language of choice.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
3. Consider how water birth options can be made available across all units.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
4. Take steps to ensure that women have contact with a consistent group of healthcare professionals, to improve continuity of care.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
5. Consider the introduction of smoking cessation leads.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
6. Consider working with Public Health Wales to further promote healthier living and lifestyles.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
7. Ensure the appropriate level of breastfeeding advice, guidance, and support is provided at all times.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
8. Review the adequacy and availability of perinatal and postnatal mental health support for women.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
9. Consider the introduction of PRAMS across its services.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
10. Ensure that staff are able to access bereavement training in a timely manner.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
11. Consider what steps can be taken to ensure that learning from women's experiences can be improved, with a particular focus on sharing what has changed in response to feedback.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
12. Consider strengthening arrangements for sharing patient stories at board and quality and safety committees.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
13. Ensure the ongoing monitoring in line with health board policy of neonatal resuscitaires and emergency medical equipment.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
14. Ensure staff awareness of procedures and responsibilities to follow in the event of a medical emergency.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
15. Ensure staff awareness of procedures and responsibilities to maintain the safety of the women using water birthing facilities.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
16. Ensure that a clutter free and safe environment is maintained across units.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
17. Ensure adequate infection control measures are in place, and adhered to.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
18. Ensure the safe storage of COSHH substances at all times.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
19. Ensure that staff are aware of their responsibilities in relation to the safe storage of medication.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
20. Ensure that the prescription and administration of medication for the induction of labour is done in line with health board policy.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
21. Ensure women have access to Female Genital Mutilation clinics.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
22. Ensure learning and service improvement actions are implemented following incidents, concerns of audit, is effectively shared with staff across all sites.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
23. Ensure that steps are taken to encourage staff to speak up and report incidents without fear of reprisal or repercussion.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
24. Ensure the timely implementation of a single maternity dashboard across Wales.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
25. Ensure that policies and procedures are updated, ensuring staff are aware of updates to maintain the delivery of safe and effective care.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
26. Ensure all midwives complete appropriate training before being required to assist in theatre.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
27. Consider the implementation of champion midwives to support further innovation and research.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
28. Consider the introduction of live stream CTG monitoring in all units.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
29. Ensure that staff have timely access to the training that is required for them to carry out their roles effectively.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
30. Review their workforce plans to ensure appropriate actions are being taken to address the impact of staff working excessive hours, and any shortfall across staff groups.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
31. Consider implementation of positive initiatives to recognise the good work carried out by staff within the midwifery and medical teams.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
32. Ensure that a high standard of documentation is maintained, in particular ensuring that the standard of patient records is improved.		
Action	**Responsible Officer**	**Timescale**

Appendix D – Welsh Government recommendations

As a result of the findings from this review, we have identified the following recommendations in the table below. Where applicable, Welsh Government should:

Recommendation		
1. Ensure that the implementation of an electronic record is achieved as soon as possible.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
2. Consider the benefits of a consistent approach across Wales to prevent baby abduction.		
Action	**Responsible Officer**	**Timescale**

Recommendation		
3. Ensure the timely implementation of a single maternity dashboard across Wales.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
4. Consider an all-Wales approach to appraisals to ensure a consistent approach.		
Action	**Responsible Officer**	**Timescale**
Recommendation		
5. Consider a review of the preceptorship programme to improve the experience for newly qualified staff.		
Action	**Responsible Officer**	**Timescale**

This publication and other information from Healthcare Inspectorate Wales can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Where present, quotes in this publication may have been translated from their original language. Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: **0300 062 8163**
Email: **hiw@gov.wales**
Website: **www.hiw.org.uk**

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh

 WG41352 Digital ISBN 978-1-80082-446-1

Hospital Inspection (Announced)

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

Inspection dates: 10 - 14 February 2020

Publication date: 21 July 2020

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

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

Digital ISBN 978-1-80038-912-0

Contents

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

Our purpose

To check that people in Wales are receiving good care.

Our values

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

Our priorities

Through our work we aim to:

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

1. What we did

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

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

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

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

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

---

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

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

2. Summary of our inspections

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

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

This is what we found the service did well:

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

This is what we recommend the service could improve:

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

3. What we found

Background of the service

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

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

Maternity services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provides care to women who chose to birth in the health board facilities who reside outside the geographical boundary.

The health board averages over 220 births per year, which has remained relatively stable over the last three years.

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

Quality of patient experience

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

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

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

Health promotion information was clearly displayed within the birthing units.

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

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

Comments from patients who completed questionnaires included:

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

Staying healthy

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

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

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

Dignified care

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

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

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

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

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

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

Patient information

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

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

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

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

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

Communicating effectively

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

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

---

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

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

Timely care

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

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

Individual care

Planning care to promote independence

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

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

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

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

People's rights

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

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

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

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

Listening and learning from feedback

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

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

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

Improvement needed

The health board must ensure that:

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

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

Delivery of safe and effective care

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

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

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

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

However, we identified areas for improvement in record keeping.

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

Safe care

Managing risk and promoting health and safety

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

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

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

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

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

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

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

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

Falls Prevention

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

Infection prevention and control

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

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

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

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

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

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

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

Improvement needed

The health board must ensure that:

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

Nutrition and hydration

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

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

Medicines management

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

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

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

Safeguarding children and adults at risk

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

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

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

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

Medical devices, equipment and diagnostic systems

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

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

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

Effective care

Safe and clinically effective care

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

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

Quality improvement, research and innovation

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

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

Information governance and communications technology

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

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

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

Record keeping

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

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

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

Improvement needed

The health board must ensure that:

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

Quality of management and leadership

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

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

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

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

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

Governance, leadership and accountability

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

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

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

Reducing Risk through Audits and Confidential Enquiries (MBRRACE)[7] and Each Baby Counts[8] were taken forward in the units. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies, such as MBRRACE, and ongoing work takes place to ensure the units are in line with the recommendations made.

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

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

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

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

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

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

Staff and resources

Workforce

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

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

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

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

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

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

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

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

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

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

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

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

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

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

---

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

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

4. What next?

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

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

The improvement plans should:

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

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

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

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

5. How we inspect hospitals

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

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the inspections

Service: Powys Teaching Health Board

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

Date of Inspections: 10 – 14 February 2020

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

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

Appendix B – Immediate Improvement plan

Service: Powys Teaching Health Board

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

Date of Inspections: 10 – 14 February 2020

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

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

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

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

Health Board Representative:

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

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

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

Appendix C – Improvement plan

Service: Powys Teaching Health Board

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

Date of Inspections: 10 – 14 February 2020

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

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the birthing pool facilities are reviewed within the Welshpool Memorial Hospital to increase birthing numbers within the unit.	4.1 Dignified Care	Maternity services are working in partnership with Capital Estates and league of friends for the installation of birth pool facilities for Welshpool Memorial Hospital. Funding has been agreed with League of Friends and pool has been ordered	Women and Children's Business Support	Timeframe delayed for installation due to COVID19 Estates work planned to commence by

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

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

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

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

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

Service representative

Name (print): Julie Richards

Job role: Head of Midwifery and Sexual Health services

Date: 26th June 2020

DASHBOARD OF IMPLEMENTATION OF HIW RECOMMENDATIONS

HIW RECOMMENDATIONS							
Ref	**Inspection Title**	**Recommendations Made**	**Recommendations Complete**	**Recommendations Overdue (agreed timescale)**	**Overdue Recommendation Revised Timescale**	**Recommendations Not Yet Due**	**All recommendations implemented**
			2017/18				
171803	Mental Health Service Inspection (Ystradgynlais Hospital)	25	18	7	0	0	*
171808	Mental Health Service Inspection (Clywedog Ward, Llandrindod)	9	5	4	0	0	*
TOTAL		**34**	**23**	**11**	**0**	**0**	
			2018/19				
181901	Ionising Radiation Regulations and Follow Up Inspection (Brecon and Llandrindod Hospitals)	10	10	0	0	0	*
181902	General practice Inspection (Presteigne Medical Practice)	15	15	0	0	0	*
181903	Joint HIW & CIW National Review of MH Services Inspection visit to (announced): Welshpool Community Mental Health Team	25	25	0	2	0	*
TOTAL		**50**	**50**	**0**	**0**	**0**	
			2019/20				
192001	Joint Community Mental Health Team Inspection - The Hazels, Llandrindod	18	15	0	3	0	*
192003	Unannounced MH Service Inspection (Clywedog Ward, Llandrindod)	23	19	4	0	0	*
192004	Unannounced Twymyn Ward, Machynlleth Community Hospital & Graham Davies Ward, Llanidloes Hospital Inspection	20	16	4	0	0	*
192006	Unannounced Hospital Inspection: Llewellyn Ward, Bronllys Hospital	13	12	1	0	0	*
192007	Birth Centres (Free Standing Midwifery Led Unit) Across Powys	9	7	0	0	2	*
192008	NHS Mental Health Service Inspection (Unannounced): Felindre Ward, Bronllys Hospital	24	11	3	0	10	*
TOTAL		**107**	**80**	**12**	**3**	**12**	
			2020/2021				
20045	Tier 1 Quality Check: Tawe Ward, Ystradgynlais Hospital	2	1	1	0	0	
20050	Tier 1 Quality Check: Maldwyn Ward, Welshpool Hospital	2	0	2	0	0	
TOTAL		**4**	**1**	**3**	**0**	**0**	
GRAND TOTAL		**195**	**154**	**26**	**3**	**12**	

Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Notice of Decision under s.20(2)

To: Powys Teaching Health Board

Of: Powys Teaching Health Board, Glasbury House, Bronllys, Powys, LD3 0LU

Following an application made under section 11(1) of the Regulation and Inspection of Social Care (Wales) Act 2016 submitted on 07/07/2020 in relation to Cottage View, Powys Health Care Nhs Trust, Knighton Hospital, Ffrydd Road, Knighton, LD7 1DF

Decision:

We have decided to grant your application to designate Jason Crowl as the Responsible Individual for Cottage View, Powys Health Care Nhs Trust, Knighton Hospital, Ffrydd Road, Knighton, LD7 1DF

Legal grounds:

Section 20(1)(b) of the Regulation and Inspection of Social Care (Wales) Act 2016.

Conditions of Registration:

The conditions of registration for this service are now as follows

1. Powys Teaching Health Board is registered to provide a Care Home Service at Cottage View POWYS HEALTH CARE NHS TRUST, KNIGHTON HOSPITAL, FFRYDD ROAD, KNIGHTON LD7 1DF
2. A maximum of 10 individuals can be accommodated at this service
3. The responsible individual for this service is Jason Crowl

This Decision takes effect:

On the date of this Notice.

Signed Carol Rice

Registration Team, Care Inspectorate Wales, Welsh Government office, Sarn Mynach, Llandudno Junction, Conwy, LL31 9RZ, telephone no: 0300 790 0126.

Dated 28/10/2020

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Haygarth Medical Centres

Activity date: 1 December 2020

Publication date: 29 December 2020

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80082-675-5

WG41462

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Haygarth Medical Centres as part of its programme of assurance work. The Hay and Talgarth Group practice provides medical care to the towns of Hay-On-Wye and Talgarth, with their surrounding villages and hamlets covering an area of approximately 450 square miles of sparsely populated countryside. The practice was a General Practitioner (GP) / medical student training practice working from two purpose-built medical centres (Hay and Talgarth). Both were designed to accommodate the needs of the practice population and had fully equipped treatment rooms.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the Practice Manager and one the practice partners on 1 December 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How has the practice and the services it provides, adapted during this period of COVID-19? What is the practice road map for returning to pre-COVID-19 levels of services?
- How effectively are you able to access wider primary care professionals and other services such as mental health teams, secondary care and out of hours currently?
- What changes have you implemented in light of COVID-19 to ensure infection prevention and control standards are maintained?
- How are you ensuring that patients (including vulnerable/at risk groups) are able to access services appropriately and safely?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We questioned the practice on how they are making sure all patients have safe and appropriate access to services.

The following positive evidence was received:

The practice manager stated that a number of changes had been made to the environment. These included communications with staff and patients, as the practice believed this was important. This was done through a number of channels including social media. We were told that there was signage outside and inside the practice with permanent floor markers, to promote social distancing. The Medical Centres had been open throughout the pandemic lockdowns and that they found ways to ensure that their patients that need to be seen were seen whilst maintaining a safe working environment. The practice had adhered to the government guidelines in respect of COVID 19 and regularly sought advice to ensure that both patients and staff were safe.

The building was locked from the inside, and patients had to buzz to come in, on a pre-arranged appointment basis. There was alcohol hand gel available for both patients and staff. Screens had been installed to protect staff working in reception and consulting rooms.

Chairs had been removed from the reception area where possible and benches had restricted seating signage, all chairs and benches had vinyl surfaces that could be wiped clean. There were staggered breaks for staff to reduce contact and there were clinical and non-clinical rest rooms. Patients could only attend one of the practice sites to prevent cross infection. If the GP needed to examine patients, in addition to personal protective equipment (PPE), there were portable screens which could be used. Staff only attend one practice site during the day to prevent cross infection when possible

We were also told about the COVID-19 icon[1] on the personal computers of all staff. This kept them up to date with Welsh Government information, cases of COVID-19 and also included downloads to send to patients. This initiative was supplied by the NHS Wales Informatics Service (NWIS).

The changes to appointments and examinations were described. These included online consultations, face to face appointments and telephone consultations. The practice manager believed that the use of online and telephone consultations were embraced by patients. Where patients could not access or use these systems, patients were also allocated an appointment in the practice.

[1] In computing, an icon is a pictogram or ideogram displayed on a computer screen in order to help the user navigate a computer system.

The introduction of nurse triage, to facilitate on the day appointment requests, was described. This developed further with the cluster pilot of Total Nurse Triage[2] for urgent and routine appointments. Total Nurse Triage enabled the practice to increase appointment times from 10 to 15 minutes. The pilot had been very successful and had proved extremely beneficial during the pandemic. We were told that despite the funding for this having stopped, the practice made the decision to continue with Total Nurse Triage and fund this service within the practice.

There was also one practice nurse working on triage remotely, due to shielding. We were told that where triage was used by staff at the practice this would be within the agreed protocols. GPs also mentored staff involved in triage. The practice nurses had all attended a local ailment course at the local university and new practice nurses attend this course within the first year of employment with the practice.

We were also told of other initiatives such as staff being able to work remotely, with everything still recorded as required. All staff working at home completed the relevant health and safety assessments for the use of visual display units.

To reduce cross contamination, each member of staff worked on a nominated work station at the practice. The practice was also a dispensing practice and deliveries continued to pre-agreed drop off points, with appropriate PPE for the delivery staff. The practice manager stated that there were daily morning briefs with the practice staff. There were individual team meetings also scheduled within the practice. Additionally, the practice manager met weekly with other managers and a representative from the local health board also attended. Rotas were produced to reduce the number of staff working at any one time thus reducing footfall within the practice. Communal rooms had a capacity notice to ensure adherence to social distancing requirements.

We saw evidence of the environmental risk assessments completed for both sites. These appeared to be comprehensive and included identification of hazards, current controls, what further action was necessary and by whom.

We were told that some clinics were maintained, such as childhood immunisations and flu clinics. Patients who required a B12 injections[3], were reviewed and as appropriate changed to a tablet medication. The practice has returned to administering B12 injections to those who need this. These were continued with a patient flow system introduced to minimise footfall and contact within the practice. Patients would arrive and wait in the car park to limit time spent in the practice. Initially the practice stopped the cervical screening clinics, but these restarted as cleaning procedures were put in place and with portable screens. More time was allocated between patients. Additionally chronic disease clinics were stopped initially, but we were told that the interactive website now allowed patients to download

[2] https://www.redkiteltd.co.uk/totalnursetriage.html

[3] The treatment for vitamin B12 or folate deficiency anaemia depends on what's causing the condition. Most people can be easily treated with injections or tablets to replace the missing vitamins. Vitamin B12 deficiency anaemia is usually treated with injections of vitamin B12.

information for these clinics.

For patients who were unable to use telephones, they could still visit the practice but they would be screened prior to entering the practice. Some clinics were also arranged to coincide with busy days in the local town, such as market day for the flu clinic.

The medical information system used at the practice would alert staff of any patients who were at risk or extremely vulnerable, if they contacted the practice, we were told. Where required, home visits would be made, if this was the most clinically effective method. Home visits were risk assessed as to whether to visit or not. If a home visit was required, we were told that there was specific PPE allocated. In addition to the visit being risk assessed, the relevant member of staff had also been risk assessed. We also saw evidence of the form used to risk assess staff as to their risk and where they should work within the practice. In order to reduce the risk to staff, telephones were moved into other offices and rooms to enable staff who had a higher risk score to be able to segregate.

Care home visits and appointments continued, we were told, online initially, but the relevant staff would also visit if appropriate, dependant on a risk assessment. A Primary Care Specialist Nurse supported by a GP and Pharmacist covers the care homes within the practice.

No improvements were identified.

Infection prevention and control (IPC)

During this process, we reviewed infection control policies, cleaning schedules and staff training. We also questioned the setting about how the changes they had introduced to make sure appropriate infection control standards were maintained. We reviewed key systems including the use of PPE.

The following positive evidence was received:

The practice manager was in charge of ensuring that there was sufficient stock of PPE at the onset of the pandemic. An element of stock was supplied through the health board. Stock control was in place in respect of PPE. Whilst initially the supply of a specific type of antibacterial wipes had to be sourced elsewhere, there was no shortage of PPE noted.

We were told that the practice created videos to assist staff in the donning and doffing of PPE, which were available on the local computer drive. One of the GPs was allocated to check individuals when donning and doffing PPE, this reinforced staff confidence.

There were a number of posters displayed around the building, including those relating to hand washing, social distancing and donning and doffing PPE. Staff were encouraged not to leave the building during the working day to reduce the spread of any potential infection. There was also a shower for the staff to use should they wish.

The changes made to the cleaning routine were described, which included a deep clean every night. Additionally the screens introduced were cleaned during the day and at night. If there was any evidence of a patient attending with COVID-19 the building was closed and deep cleaned.

There were disposable curtains in the consulting rooms that were monitored regularly with a maximum of a six monthly replacement schedule in place. The changes made to the cleaning routine were described, which included a deep clean in every room, every night in the rooms where patients had been present. If there was any evidence of a suspected COVID-19 patient, the curtains were replaced. We saw evidence of the comprehensive cleaning schedules for both sites.

We also viewed the standard operating procedure for cleaning between patients, which aimed to ensure a high level of infection control was maintained in patient contact areas, for the safety of staff and patients during COVID-19.

We were told that clinicians who were required to carry out a home visit, after being risk assessed, were supplied with specific packs which included wipes, gel and masks. An oximeter, to take oxygen levels, together with waste bags in which to dispose of the contaminated waste were also included. Similar packs were also allocated to every consulting room together with an information sheet advising the patient as to what was happening. These packs were allocated to every consulting room

In order to reduce the possibility of patients visiting the surgery with suspected infectious illnesses, we were told that initially patients were triaged by phone. Then patients, where there was any doubt as to their infection status, were told to come into the surgery car park and a GP would don PPE and consult with them in the car, as necessary. Where there was still a doubt and the patient needed treatment, they would come into the treatment room directly from the outside, without going through the surgery. The PPE used was then double bagged for secure disposal and the room was deep cleaned.

We saw evidence of the Infection Control Inspection Checklist Audit carried out in November 2020 and the actions taken as a result of this internal check. There were a number of infection control documents used at the GP surgery, which were all in date, including the Infection Control Protocol and Infection Prevention Policy. This document set out the practice policy on infection control.

No improvements were identified.

Governance

As part of this standard, HIW reviewed policies and procedures for future pandemic emergencies. We also questioned the setting about how they have adapted their service in

light of the COVID-19 pandemic, how they are interfacing with wider primary care professionals and their risk management processes.

The following positive evidence was received:

We saw evidence of the adaptations that the practice made initially, in the form of an email at the beginning of the pandemic. This included stating that all routine appointments would be by telephone or video consultation. There was one triage list for both emergency and routine appointments, and routine bookable appointments were stopped. Regular communication continued throughout the pandemic advising staff of changes and developments and continue to do so regularly. Staff meetings were held virtually as a form of reassurance to staff.

The arrangements for clinics were made known, including contraceptive injections continuing and birth control pill prescribing was discussed over the telephone. Photographs when required for consultation were accepted through a secure online system. Information would be scanned and coded into the information system at the practice, even whilst remote working.

We were told that whilst chronic disease clinics were initially postponed, if needed the surgery would go through a triage process with the patient. If patients had a blood pressure machine, they were encouraged to post the information securely through the practice website. Also joint injections were postponed due to the risks involved. All services had now recommenced.

We saw evidence that the practice had engaged with an employee assistance programme, that assisted staff with personal problems or work-related problems that may impact their job performance, health, mental and emotional well-being. Staff were given flexibility in their work patters and all staff working that day had access to a virtual team meeting where the day was discussed and this assisted with communications.

Weekly partners meetings with the partners and management team. The daily team briefs in the morning also supported all our staff and keeps the staff fully informed and increases morale.

We were told that there was communication between the health board and the practice, this meant that the practice felt able to go to the health board if there were any issues that required health board involvement or assistance. The Powys practice managers held a monthly meeting, with a member of the health board in attendance.

The practice was part of the South Powys cluster[4] of four GP practices who formed a

[4] A cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. Clusters are determined by individual NHS Wales Local Health Boards (LHB's). GPs in the cluster play a key role in supporting the ongoing work of a Locality Network.

Community Interest Company[5] (CIC) called Red Kite Health Solutions in 2015, to deliver health and wellbeing services. They met regularly to look at services that could be facilitated for the benefit of their patients. We were told of the pandemic cluster initiative that looked at referral patterns, compared with the same period last year to ensure that the levels of activity were maintained, particularly in relation to cancer referrals. The four practices had a sharing agreement enabling the GPs and triage nurses to provide support if required.

We were told of the CIC application for National Lottery Funding to deliver a COVID 19 impact Service has been successful. This service would directly assist patients who had shielded or who are vulnerable through a telephone support during the next 12 months. The service would also increase and promote crucial health checks, in addition to signposting patients to available community support services when required. Additionally, this service would also target non-responder patients who were overdue cancer screening and other chronic health condition reviews.

Whilst we were told that opening times stayed the same during the majority of the pandemic, from October 2020, the reception area was closed on one site in the afternoons. The dispensary remained open and prescriptions were available throughout the afternoon, every day on both sites, patients could also still telephone the practice. Consultations would continue to take place but the reception was closed to enable the receptionist to complete other work. We were told that these changes were communicated through a number of channels including social media, the practice website, the practice newsletter, posters in the community and also via a local free magazine. Additionally, information in the form of a mini newsletter was also attached to all prescriptions. The GPs met with local councillors and there was also a newsletter on the practice website. The practice also met with the local Community Health Council[6] (CHC). We were told that if this happened outside the pandemic, there would also have been a public forum meeting.

We were provided with evidence of the current training data for all nursing staff in infection control, which showed that they were trained and in date at least to level 1.We were told that information relating to COVID-19 was accurately recorded and reported on a timely basis. All results were dealt with on the day received and reviewed twice daily and cascaded as necessary for clinician review. The practice manager checked the coding and scanning on a regular basis.

The access to the wider GP cluster was described, as was the out of hours (OOH) service called SHROPDOC[7]. This service was described as “excellent” by the practice manager. Initially when the pandemic started, this service supported patients with a management service online to

[5] A community interest company is a type of company introduced by the United Kingdom government in 2005 under the Companies Act 2004, designed for social enterprises that want to use their profits and assets for the public good.

[6] Community Health Councils (CHC) are the independent voice of people in Wales who use NHS services. They are made up of local volunteers who act as the eyes and ears of patients and the public.

[7] Shropdoc is a not-for-profit company established in 1996. We provide urgent medical services for patients when their GP surgery is closed and whose needs cannot safely wait until the surgery is next open. We work closely with NHS 111 to ensure urgent health needs are met as quickly as possible.

reduce the pressure on GPs. Arrangement and communication with out of hours services had continued, with any reports being downloaded onto the practice notes as were any visits or telephone calls for the attention of the duty doctor.

The systems of working with other agencies were described, such as the pharmacy and allied health professionals. The practice also worked with the Powys Association of Voluntary Organisations (PAVO)[8]. The optician near the surgeries would take referrals and perform a full assessment on eye problems including a Primary Eye-Care Assessment and Referral Service[9].

We were told that one hospital used by the practice had suspended routine operations, but they are now reverting to normal service. Also mental health services used to be based in the practice before the pandemic, and the practice would rather they were available in the practice to discuss any issues. We were told that there had not been any changes to patient discharge arrangements from secondary care.

No improvements were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it 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 Quality Check.

As a result of the findings from this quality check, 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.

[8] http://www.pavo.org.uk/

[9] The Primary Eyecare Acute Referral Scheme (PEARS) and the Welsh Eye Health Examination (WEHE) schemes are part of an all-encompassing Welsh Eye Care Initiative (WECI). The PEARS and WEHE schemes are intended, respectively, to facilitate the early assessment of acute ocular conditions and to case-find ocular disease in at-risk individuals.

Improvement plan

Setting: Haygarth Medical Centres

Date of activity: 1 December 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	No improvements identified				

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.3

Experience, Quality and Safety Committee	**Date of Meeting: 4th February 2020**
Subject :	**Mortality Review (Community Hospital Deaths)**
Approved and Presented by:	Paul Buss, Medical Director
Prepared by:	Howard Cooper, Safety & Quality Improvement Manager
Other Committees and meetings considered at:	Executive Committee

PURPOSE:

This purpose of this paper is to provide an update to Experience, Quality & Safety Committee on the mortality review process implemented across the Health Board together with actions that are being taken to show improvement.

RECOMMENDATION(S):

The Experience, Quality & Safety Committee is asked to DISCUSS and NOTE the content of this paper.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	
	2. Provide Early Help and Support	
	3. Tackle the Big Four	
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	
	6. Promote Innovative Environments	
	7. Put Digital First	
	8. Transforming in Partnership	
Health and Care Standards:	1. Staying Healthy	
	2. Safe Care	
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	
	6. Individual Care	
	7. Staff and Resources	
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

This paper describes the results of a new approach to mortality reviews in Powys Teaching Health Board where senior clinicians from the organisation undertake an independent review of deaths occurring in Powys Community Hospitals.

The paper also provides an update on the Datix Mortality Module and the roll out of the Medical Examiner project.

Finally, the paper provides a summary report on the deaths of Powys residents occurring both in Powys community hospitals and in the services commissioned in out of county District General Hospitals during the period 1st September 2020 to 31st December 2020.

DETAILED BACKGROUND AND ASSESSMENT:

Introduction

Powys has a strong tradition of undertaking mortality reviews for patients who die in our community hospitals. In July of 2009 Powys became the only Welsh Health Board to pilot the Medical Examiner role, alongside five other organisations in England. Dr John Buchan, a retired Powys GP, was appointed as the Powys Medical Examiner and provided vital feedback to the national group within the Department of Health that was shaping future policy.

The original goal of the Medical Examiner project was to remove the unfettered right of doctors to sign the death certificate of patients they had personally treated, as this process had been abused by Dr Harold Shipman to disguise the murders he had

committed. The role of the Medical Examiner was to examine the care provided and formally advise doctors on appropriate wording for death certification. However, by 2012, more than a decade had passed since the crimes of Shipman and the feeling of urgency had dissipated. It was decided nationally to wind up the project.

Powys Health Board felt however that this examination of patient care was a very useful undertaking and retained Dr Buchan to utilise the relationships that he had developed with the Powys medical community to establish a mortality review process at each of our hospital sites. This put Powys in a good place when, in 2014, it became the Welsh Government's policy to review all in-patient deaths in response to the findings of the Palmer report on the previously used statistical model for mortality.

The New Approach to Mortality Reviews

Although these local reviews of in-patient deaths have been highly effective in the recent years, it is a fair criticism to say that the process lacks independent scrutiny. To address this issue the Medical Director formed a Senior Clinical Review team consisting of himself, the Assistant Medical Director and the Head of Nursing. In September 2020 they gave themselves the task of reviewing the notes of patients who had died in Powys community hospitals during 2020. A maximum of 15 cases was set for each site so that each site would have an equal sampling of the care provided.

Eight community hospital sites were each visited by a single case reviewer, Knighton not being included in the review as it had been closed to in-patient care as part of the Covid 19 pandemic preparations. Case notes were reviewed for a total of 104 patients.

All the reviewers reported that visiting the sites had been a very positive experience both for themselves and the staff working there. Staff were very happy with the interest that was being shown in their work by senior management and were keen to show off the care provided. The opportunity to feed back positive comments to the ward staff has been warmly welcomed.

The process followed by the reviewers was based on the previously developed All-Wales Universal Mortality Review (UMR) tool with a separate written record being made of the review for each set of notes. At the end of each of these "Stage 1" case reviews the reviewer decided whether all aspects of the care were completely satisfactory and the case could be closed, or whether there was some aspect of either positive or concerning practice that should be brought forward to a "Stage 2" panel review.

The reviews were based on the written clinical record only and staff were not formally interviewed about the care provided.

The reviewers concluded that six cases should be brought forward to the Stage 2 panel review whilst 98 could be closed as being satisfactory after the Stage 1 review.

Findings of the Stage 2 review

The Senior Review Team met in December 2020 to discuss the general and specific findings of the Stage 1 reviews and to undertake a Stage 2 review of the six cases brought forward.

As a general finding all reviewers commented that the written patient records were of high quality, with one reviewer describing them as "superb". The notes demonstrated good communication with the family of the patient, and the care provided seemed entirely appropriate and timely. On wards where it was employed, the use of real time documentation was noted as working particularly well, giving a level of detail that would be reassuring to the family of the patients.

The reviewers noted that completion of the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form was done to a very high standard, though it was noted that the form wasn't always displayed prominently in the front of the notes.

Some minor issues were identified. One was that the original reason for admission, though it could be generally found somewhere in the record, wasn't given in a consistent or obvious place in the notes.

It was also noted that for palliative patients, whilst the actual end of life care was provided in an exemplary manner, the specific documentation pack intended for use during the last days of life was used for only half of the patients. This perhaps reflects the reluctance of clinicians to use a formally documented pathway given the public criticism of other formal measures such as the Liverpool Care Pathway in past years.

General learning points from Stage 1

A discussion was held concerning dying patients who were unable to have visits from family due to restrictions being placed on visiting during the Covid 19 epidemic. The Medical Director suggested that the Health Board should consider its policy so that this issue can be sensitively addressed should there be ongoing restrictions due to the epidemic.

There were three cases where the death was related to a hospital-acquired Covid 19 infection. However, in terms of clinical care it was considered there was no other course of treatment that would have been more effective or appropriate for these patients.

The cases will be reviewed more fully however as part of a further piece of work that plans to review nosocomial infections as part of a national programme.

Another identified shortcoming was that the notes did not always explicitly record the cause of death of the patient. This should be added as a final entry as it will aid the work of the Medical Examiner when that service is introduced. A very positive finding however was that at two sites a copy of the Medical Certificate of Cause of Death was already included in the patient notes.

Specific Learning Points from Stage 2 reviews

One of the cases was brought to the Stage 2 review simply because it was unclear what the patient, who had a very complex medical history, had actually died from. There were no specific concerns about the care provided but a final summary written in the notes would have been an act of respect towards the patient and would have greatly helped the reviewer.

Four cases that were reviewed at Stage 2 related to the failure to report incidents on Datix contrary to PTHB policy. Three concerned pressure damage that the patient

was found to be suffering from on admission and the fourth concerned the loss of patient property after the death of the patient. The Assistant Medical Director and the Head of Nursing agreed to follow up these cases after the meeting.

The final case was the only one which raised some clinical concerns. The patient was clearly palliative and on a rapidly terminal trajectory but the Medical Director believed there might have been some interventions that would have been appropriate to give. These were not documented as having been given, nor a rationale for not giving them recorded in the notes. Whilst patients and their families do not want aggressive levels of treatment it should not prevent the Health Board from offering basic, simple treatments for all patients, even those nearing the end of their lives.

It was decided that this case should be returned to the hospital team so that they may review the case and determine whether any learning arises from the treatment decisions that were made.

Future Work
This new approach of a senior group of clinicians undertaking an independent mortality review has been warmly received by the organisation. A further round of reviews will be planned once the new Medical Director has taken up office. The process has allowed for the high quality of care provided by staff to be recognised whilst giving an independent level of scrutiny to the services offered by our community hospitals.

The Datix Mortality Module and the Medical Examiner Role

The Once for Wales Concerns Management System (OfWCMS) had hoped to establish the core functionality for the Learning from Mortality system to ensure that mortality reviews can be undertaken in a consistent, evidence-based manner in order to identify problems in care and maximise and promote system learning.

Unfortunately, implementation of this module has been delayed by two factors outside the control of the Health Board. The first has been technical issues in the software development that have impacted on the final release of the module. In order to achieve full functionality, the module relies on a sophisticated indexing system that allows for data to be pulled between the Mortality, Complaints and Incidents Datix modules as well as outside sources of information such as those held by the Office for National Statistics. The Datix developers have not yet managed to achieve a stable build of this system. Powys Health Board has completed all preliminary work however and would be able to undertake any piloting work should a usable version of the system become available.

The second has been developments in the Medical Examiner Programme. Here work is progressing well with staff who will cover the Powys region already in post. Discussions are ongoing however with regard to the software and databases these staff will use and one possibility is that the Datix mortality module will be taken over by the Medical Examiner service for their use.

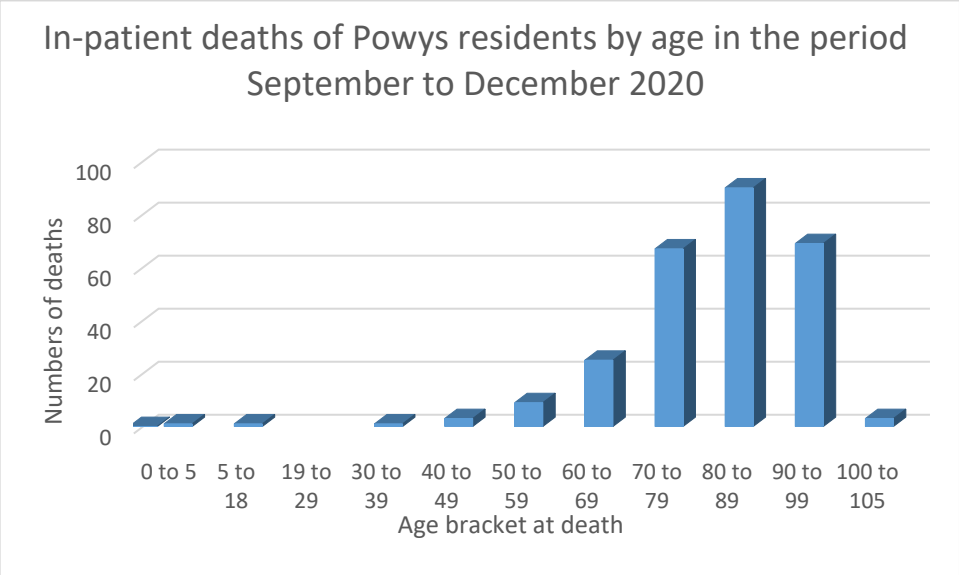
Further reports will be submitted to the Experience Quality and Safety Committee once the final disposition of these resources has been determined.

Deaths of Powys Residents in Hospitals (1st September 2020 – 31st December 2020)

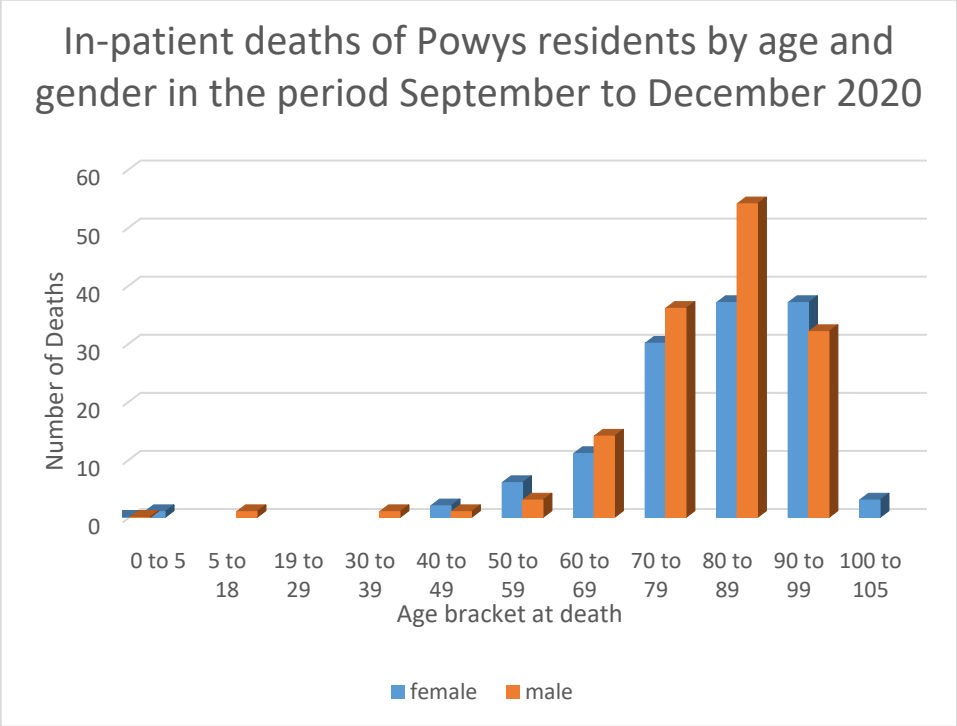
During the period under review there have been the following deaths of Powys residents in either Powys community hospitals or in acute units of neighbouring Health Boards and NHS Trusts.

Deaths in Powys community hospitals	74
Deaths in acute units in neighbouring English NHS Trusts	114
Deaths in acute units in neighbouring Welsh Health Boards	81
Total number of deaths that were subject to a serious incident (SI) investigation	0
Infant and child deaths	< 5
Perinatal deaths	0
Maternal Deaths	0

The graph below demonstrates that the majority of deaths of Powys residents in all hospitals are of people over the age of 60 with the greatest number being those aged between 80 and 89 years of age.



The graph below breaks these deaths down by gender.

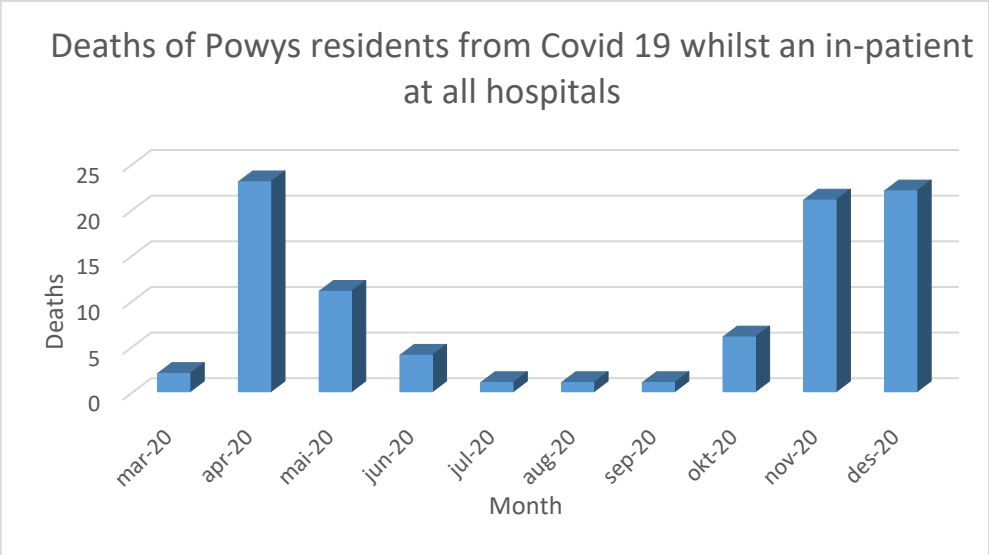


The table below gives the primary cause of death of these patients.

- 'The Big Four' Cancer, Mental Health, Respiratory and Cardio Vascular
- Dementia
- Covid-19
- Other

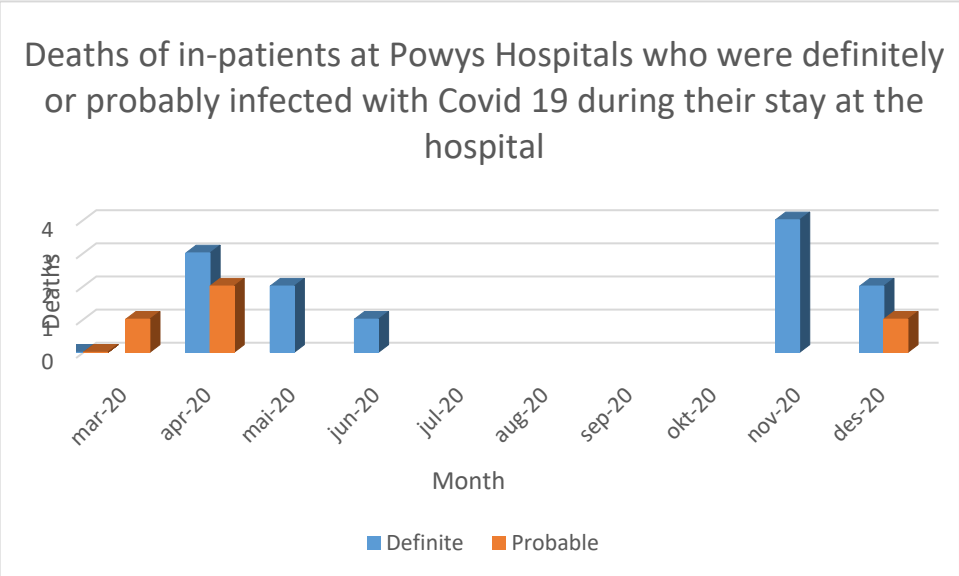
	Primary Cause of Death	PTHB Provider Male	PTHB Provider Female	Commissioned Services: Male	Commissioned Services: Female	Total
The Big Four	Cancer	15	17	22	12	66
	Mental Health	0	0	0	0	0
	Respiratory Disease (not Covid 19)	0	2	19	16	37
	Cardiovascular Disease	5	5	24	18	52
	Dementia	3	5	7	4	19
	Covid 19 (includes cases awaiting lab confirmation)	0	11	24	15	50
	Other causes	6	4	17	18	45
	Total	**29**	**44**	**113**	**83**	**269**

The next graph shows the numbers of deaths of Powys residents from laboratory confirmed or suspected Covid 19 infection over the course of the pandemic which occurred in either Powys community hospitals or in out of county providers.



Nosocomial Infections

The next graph shows the numbers of Powys residents who died after becoming infected during their stay at a Powys community hospital.



RECOMMENDATIONS:

The Experience, Quality and Safety Committee is asked to note the findings of this report and progress achieved in improving the arrangements for the review of patient care.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item: 3.4

Experience, Quality and Safety Committee	**Date of Meeting: 04 February 2021**
Subject:	**Safeguarding Update**
Approved and presented by:	Alison Davies Executive Director of Nursing and Midwifery
Prepared by	Jayne Wheeler Sexton Assistant Director Safeguarding and Public Protection
Other Committees and meetings considered at:	Reports related to the content of this report are received at the Safeguarding Group

PURPOSE:

To provide the Experience, Quality and Safety Committee with assurance in relation to the way in which safeguarding and public protection has been discharged during the covid 19 pandemic.

RECOMMENDATION:

Experience, Quality and Safety Group is asked to **NOTE** the contents of this paper.

Approval/Ratification/Decision	**Discussion**	**Information**
	x	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	
	8. Transforming in Partnership	✓
Health and Care Standards:	• Staying Healthy	✓
	• Safe Care	✓
	• Effective Care	✓
	• Dignified Care	✓
	• Timely Care	✓
	• Individual Care	✓
	• Staff and Resources	✓
	• Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

The Coronavirus Act 2020 became law on the 26th March 2020, changes were made to the Social Services and Well-being (Wales) Act 2014, however the Act did not make any changes to the Safeguarding duty PTHB'S position has not changed during the Covid-19 Pandemic, safeguarding and public protection has remained a key priority during this uncertain and unprecedented time.

In summary, the Experience Quality and Safety Committee can take assurance that the focus on safeguarding and public protection has been maintained throughout the pandemic, albeit an exceptional period whereby the circumstances and effects on families, communities and society as a whole are unprecedented, likely to evolve over time and have far reaching effects across generations.

DETAILED BACKGROUND AND ASSESSMENT:

1. Background

The Coronavirus Act 2020 became law on the 26th March 2020, changes were made to the Social Services and Well-being (Wales) Act 2014, however the Act did not make any changes to the Safeguarding duty. We have continued throughout the pandemic to have a Legal duty to report safeguarding concerns.

Similarly, other legislation that drives the Health Boards 'Safeguarding agenda' has not changed, these include Violence against Women, Domestic Abuse, Sexual Violence, Exploitation, Mental Capacity and Deprivation of Liberty Safeguards.

2. Assessment

2.1 In terms of visibility and reporting, a Board development session has been dedicated to safeguarding and public protection and the annual safeguarding report has been presented to the Board. The Safeguarding Strategic Group has continued to meet quarterly. New Terms of Reference have been agreed. Key issues in relation to Safeguarding and Public Protection activity across PTHB are presented using a new Data Set which will assist in identifying good practice, themes, issues, risks and providing assurance to support PTHB demonstrate how it is meeting its statutory responsibilities for safeguarding and public protection.

2.2 Strategic implementation groups to progress key pieces of legislation were suspended by Welsh Government in April 2020, these include; the Childrens (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020 and the Liberty Protection Safeguards Strategic Implementation Group for Wales, both groups have now recommenced.

2.3 Development of the Regional SARC Model was suspended in March 2020. Meetings have recommenced with the health board as a key stakeholder, the project is reviewing how to focus on the South Wales SARC programme's priorities and clarify the governance structure, to ensure that the key service deliverables and ISO accreditation compliance are achieved.

2.4 The new Wales Safeguarding Procedures (2019) became operational in April 2020. They replace the All Wales Child Protection Procedures and the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse. Promotion of the new procedures has taken place throughout the health board. All safeguarding polices, protocols and training materials have been updated to reflect the changes.

2.5 Measuring the effectiveness of health services and their contribution to safeguarding adults and children is difficult and complex. The NHS Safeguarding Maturity Matrix (SMM) is a self-assessment tool which addresses the interdependent strands regarding safeguarding; service quality improvement, compliance against agreed standards and learning from incidents and reviews. The self-assessment tool is completed by each NHS Health Board and Trust annually and

submitted to the Chief Nursing Officer in Welsh Government via the NHS Wales Safeguarding Network.

2.6 PTHB's Safeguarding Maturity Matrix Improvement Plan was submitted to the NHS Wales Safeguarding Network in October 2020. All Safeguarding Strategic Group members had the opportunity to contribute to the evidence table from which we collectively agreed a score to each key element. The SMM Score for 2020/21 was 4 out of 5, this was the same as the previous year. A SMM Improvement Plan has been developed and will be monitored at the strategic safeguarding group.

3. Referrals and intervention

3.1 **Child Safeguarding Reports:** Child reports to the LA in Q1 remained relatively stable, in Q2 a slight rise was noted, followed by a significant increase in Q3. Domestic abuse, Care and Support and neglect being the main reasons for referral in Q3.

The increase in reporting rate can possibly be attributed to the changes in how practitioners engaged with families during the first lockdown as face to face contacts were reduced virtual contacts increased. Nationally it has been anticipated as children and families become more visible with home and clinic visits increasing, and as children returned to school, safeguarding reports would increase. Consideration should also be given to the level 3 Safeguarding training delivered to staff which may have influenced and improved safeguarding practice and knowledge.

3.2 **Adults Safeguarding Reports**: Adult reports increased during Q2 and Q3. The reason for reports varied across the categories of abuse including, emotional abuse, domestic abuse and physical abuse.

In October PTHB Safeguarding Team started to quality assure all MARF's. The majority of MARFs are appropriately completed, however there are more issues with the administration aspects such as delays in attaching the MARF to the DATIX or a password being left on the MARF, pathways have been developed to guide practitioners in this process. Issues are being dealt with as they come to light.

3.3 **Child Protection Medicals:** The number of children who underwent a child protection medical has remained stable in Q1, Q2 and Q3. New National Standards for child protection medicals was published in October 2020. Implementing and auditing the New Standards has been identified as an action in the Safeguarding Maturity Matrix Improvement Plan. A new CP Pathway to support out of hours CP Medicals has been established with CTUHB. This will provide a service

for out of hours CP medicals, if the medical is urgent and cannot wait until a Powys Community Paediatrician is available.

3.4 **Looked After Children (LAC)** The health of Powys Looked after Children (LAC) and Children in the Care of Other Local Authorities residing in Powys is the responsibility of PTHB. There is a statutory requirement for PTHB to provide health assessments for Looked after Children. LAC assessments in the main continue to be completed over the telephone, some have taken place in safe outside spaces following a risk assessment, this has been in line with the National Guidance and with the support of the National Safeguarding Network LAC Steering Group.

A multi-agency meeting to support children's homes response to Covid 19 continue to meet weekly, this has enabled a proactive approach to any concern, issue, or sharing of good practice regarding testing, PPE, contacts and outbreaks of Covid 19.

Looked after Children living in Powys has raised from 359 in June to 396 in September. The Local Authority plan a recruitment drive for foster carer in early 2021, the aim is to keep Looked after Powys children in Powys. Monitoring the LAC figures will enable us to plan for a potential increase in LAC assessments.

3.5 **Consent:** With the roll-out of COVID-19 vaccinations PTHB developed guides to share knowledge and reinforce good practice in consenting patients for the new COVID-19 vaccinations, and to empower clinicians to have meaningful engagement with vaccine recipients. Before giving a COVID-19 vaccine, vaccinators must ensure that they have obtained informed consent from the patient or that a best interest decision has been made if the patient does not have mental capacity at the time of vaccination being administered.

3.6 **Mental Capacity Act, Deprivation of Liberty Safeguards & LPS:** The Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) has not been waived by the COVID 19 Act. As a result of the clear restrictions on visiting hospitals, residential and nursing care homes since the outbreak of COVID-19, the Mid and West Wales Safeguarding Board Region agreed a regional process to managing Deprivation of Liberty Safeguards (DoLS) applications and authorisations. The majority of best interest and DoLS assessment continue to be carried out remotely, if required and when necessary face to face contacts can be arranged following an individual risk assessment.

PTHB DoLS applications have steadily increased from Q4 2019/20 (70) to 113 in Q3 2020/21, this is despite reduced activity on some of the ward in Q1. The amount of outstanding applications has risen

slightly and in line with the increase in numbers. We are unsure what accounts for this increase, however training in MCA and the availability of an e Bulletin and 7-minute briefing on MCA may be supporting practitioner knowledge and skills. MCA Training become mandatory for all forward-facing staff in September 2020.

DoLS Signatory Training took place in October to increase the Health Boards capacity to authorise DoLS. Each authorization will now require 2 signatories to work together to agree the authorisation adding greater scrutiny. Supervision for BIAs and DoLS signatories commenced January 2021, this is being facilitated by an external provider. DoLS care plans have also been introduced to all wards.

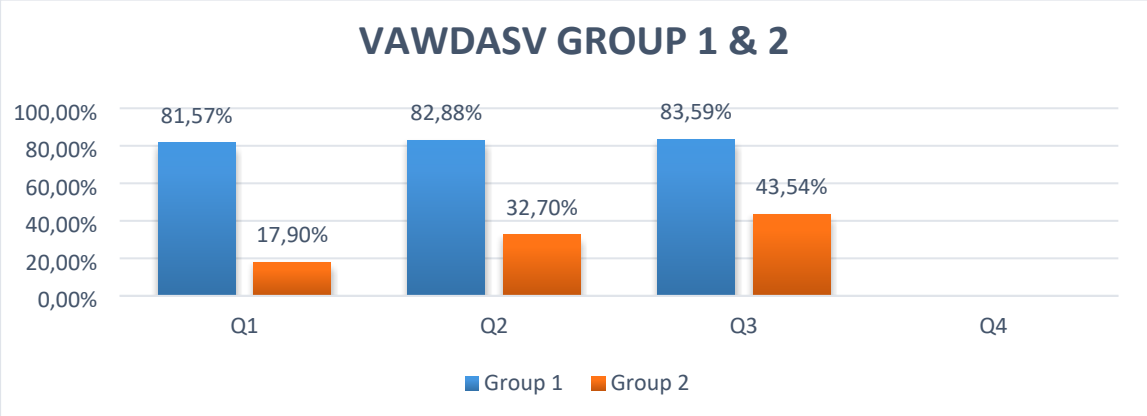
3.7 **Deprivation of Liberty Safeguards Improvement Plan**: the DoLS Internal Audit review undertaken by NHS Wales Shared Services Partnership (NSSP) in 2019 gave a Limited level of assurance. The majority of actions contained within the DoLS Improvement Plan have been completed, with the exception one action, to establish a Service Level Agreement is being progressed this quarter.

LPS will replace DoLS in April 2022, the HB must prepare for what will be a significant change to how we lawfully deprive someone of their liberty. A mapping exercise to support preparation for LPS will commence in March 2020. It is anticipated the MCA Code of Practice will be ready for consultation in Spring 2021.

3.8 **Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASW)** has far reaching consequences for families, children, communities and society. Not everyone who has to follow the stay at home guidance to combat coronavirus is in a place of safety. During April and May Dyfed Powys Police recorded a 39% drop in calls about Domestic Violence. The 3rd sector, DA Services and SARC referrals all reported a drop-in contact with victims ranging from 60 to 80%.

By June 2020 DA referrals were back to their pre Covid 19 level, local support agencies reported the abuse that was being presented appeared to be more complex and required specialist support. Some reviews report VAWDASV has become a silent pandemic. To increase awareness, newsletters have been produced to remind staff, when safe to do so, to make every contact count and apply a low threshold for asking about domestic abuse. Practitioners have also been asked to consider colleagues, friends, relatives and neighbours who might be victims of abuse. PTHB Safeguarding Team have now produced 8 Newsletters relating to VAWDASV which have been circulated via Powys announcements and our representatives on the operational safeguarding group.

The safeguarding Team have contnued to offer VAWDASV Group 2 Training via MS Teams. There as been a steady increase in compliance over the past 6 months.



3.9 **Learning**: A suite of training material has continued to be produced to give practitioners a flexible, blended approach to learning. This includes development of You Tube training slides, Newsletters and Safeguarding Briefings.

i. PTHB Safeguarding News Letter
ii. PTHB | Safeguarding Team Newsletters
iii. PTHB 7 Minute Briefings
iv. PTHB | PTHB Safeguarding 7 Minute Briefings
v. PTHB Safeguarding Monthly Briefings
vi. PTHB | Safeguarding Monthly Briefings (wales.nhs.uk)
vii. PTHB Modular Training
viii. PTHB | Safeguarding Level 3 Modular Training

Level 1 and 2 training compliance has remained above 80%. Level 3 adults and children is increasing slowly, we will continue to offer support to professionals to achieve these competences and will continue to monitor via the safeguarding strategic group.

In summary, the Experience Quality and Safety Committee can take assurance that the focus on safeguarding and public protection has been maintained throughout the pandemic, albeit an exceptional period whereby the circumstances and effects on families, communities and society as a whole are unprecedented, likely to evolve over time and have far reaching effects across generations.

NEXT STEPS:

Next steps include:

- Progressing the Safeguarding Maturity Matrix Improvement Plan
- Establish a Task and Finish group to scope the potential impact of LPS and support the Health Boards preparation for its implementation in April 2022

- Develop regular updates to share throughout the health board on the progress of the Childrens (Abolition of Defence of Reasonable Punishment) (Wales) Act 2020
- Explore the development of a PRUDiC Response and Practice Review Group

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda item: 3.5

EXPERIENCE, QUALITY & SAFETY COMMITTEE	**Date of Meeting: 04 February 2021**
Subject :	**COVID-19 Incident Management Update Report**
Approved and Presented by:	Director of Public Health
Prepared by:	Consultant(s) in Public Health
Other Committees and meetings considered at:	None

PURPOSE:

The purpose of this paper is to provide assurance to the Experience Quality and Safety (EQS) committee of the appropriate organisation, operation and effectiveness of the local outbreak management response within Powys during the COVID-19 pandemic.

RECOMMENDATION(S):

The Experience Quality and Safety (EQS) committee is asked to **NOTE** and **DISCUSS** the contents of the report, specifically the purpose and structure of the IMT, its role in investigating and managing incidents locally, and how it shares its learning and reports nationally.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVE(S) AND HEALTH AND CARE STANDARD(S):		
Strategic Objectives:	1. Focus on Wellbeing	✓
	2. Provide Early Help and Support	✓
	3. Tackle the Big Four	✖
	4. Enable Joined up Care	✓
	5. Develop Workforce Futures	✓
	6. Promote Innovative Environments	✓
	7. Put Digital First	✖
	8. Transforming in Partnership	✓
Health and Care Standards:	1. Staying Healthy	✓
	2. Safe Care	✓
	3. Effective Care	✓
	4. Dignified Care	✓
	5. Timely Care	✓
	6. Individual Care	✖
	7. Staff and Resources	✓
	8. Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

A standing multiagency incident management team has now been in place since October 2020. Its role is to have oversight of outbreaks and incidents associated with COVID-19 in Powys, with the aim of early identification and management of incidents and outbreaks. It also has an overarching view of the local epidemiology of incidents and trends of virus spread.

The IMT has led on a number of successful interventions to control and limit outbreaks. This has included the use of social media, community engagement, enhanced testing and isolation advice through to enforcement measures in some instances.

The work of the IMT has been successful in managing incidents and outbreaks to limit spread, and Powys incident rates have remained in line with or below other similar areas in Wales.

The incident management team is being chaired by the Executive Director for Public Health on behalf of Powys Teaching Health Board and operates in line with *The Communicable Disease Outbreak Plan for Wales* (2020). Statutory responsibility for the control of infectious diseases remains with the local authority and Public Health Wales.

DETAILED BACKGROUND AND ASSESSMENT:

Throughout the COVID-19 pandemic outbreaks and incidents have been managed in line with both local and national guidelines for the management of incidents to control communicable disease outbreaks – in particular, *The Communicable Disease Outbreak Plan for Wales* (2020). This describes in some detail the expected arrangements for outbreak management. Early on, incident management teams (IMTs) were established to deal with isolated outbreaks, while, currently, high case incidence rates and concurrent outbreaks mean there is a single IMT covering all outbreaks.

IMT Structure

Since October 2020, a permanently standing Powys COVID-19 incident management team has been in place to manage and address the rising incidence and spread of the virus in the county. Responsibility for managing incidents/outbreaks is shared by all the organisations who are members of the IMT.

The IMT is chaired by the Executive Director of Public Health, with core membership including PCC Director of Public Protection (or deputy), and PHW Consultant in Communicable Disease Control (CCDC). Co-opted members include members of the Test, Trace, Protect service, environmental health officers, communications leads and consultants in public health. The terms of reference for the IMT, including the full membership is shown in appendix 1.

IMT Operation

Currently, the IMT meets three times a week. During each meeting there is a review and update on clusters and population areas with higher than expected rates of infection. Potential causes for increases in cases are discussed and any new control measures are agreed. If required, colleagues from areas bordering Powys are asked to join the IMT for relevant items.

It is the role of the IMT to support the implementation of national guidance and restrictions imposed in terms of isolation and quarantine, but also to enhance local measures using tools such as public messaging and enforcement notices to promote compliance.

Another important area of work is ensuring that there is adequate access to testing and that local communities are aware of how to access testing. There are a number of approaches to testing that include opening up access to areas that appear to have low levels of positivity, and also increasing access in areas of higher demand and higher positivity to make testing as easy as possible.

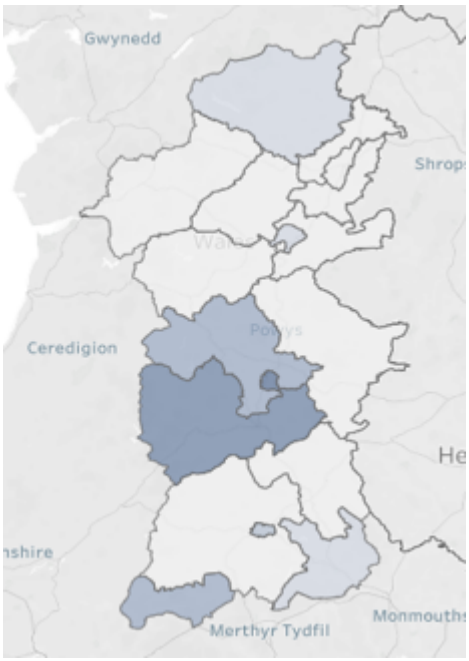
The main operational risk to the IMT is staffing, in particular the limited specialist health protection and public health workforce available to support the response to incidents. At the present time, there are between 20-30 separate incidents running concurrently, each constantly evolving and each requiring decisions to be made about testing, isolation and quarantine, inspection and contact tracing. The small specialist public health workforce has now been at this for a long time, having worked exceptionally hard since the very beginning of the pandemic at the start of 2020. Approaches have and are being put in place to try and enhance resilience, but it still remains the case that this is a fragile aspect to the response where there are no easy mitigations available.

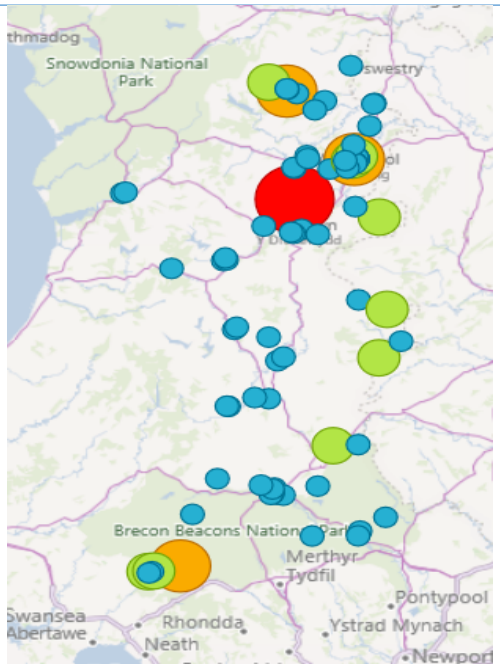
Surveillance and escalation levels

The IMT receives a daily Health Board epidemiological summary report which provides a rolling 7 day incidence rate per 100,000 and the positivity rate by local authority area. This report shows trends and comparison with other local authorities in Wales. The information provides an overarching view of the current position and which alert level Powys is within.

There are a number of additional national reports which are shared and utilised by IMT on a regular basis, this includes a bi-weekly COVID Local Authority (LA) review which shows trends and comparable data by all local authorities. These reports provide a snapshot of confirmed COVID-19 cases, broken down by age group, testing venues and by medium super output area (MSOA).

At each IMT the most up to date data is considered along with local intelligence from the Powys contact tracing system, which can provide real time data. The two maps below illustrate the type of information available to the IMT:





All this surveillance information is used to determine actions and strategies to limit spread and predict further spread which enable the team to plan interventions.

Reporting - Internal
The IMT members, as part of a multiagency forum, have the responsibility to report back to their individual organisations, while also having the delegated authority to act on behalf of their organisations. Powys Teaching Health Board and Powys County Council have set up a clear governance structure with reporting through the Prevention & Response Group to both organisational Gold(s).

Reporting – External
Whilst the Powys wide IMT has been in place there has been a requirement to report to Welsh Government on a regular basis using the situation, background, assessment, recommendations (SBAR) methodology. This is currently required weekly, with an SBAR submission taking place every Monday.

Substructures of IMT
With the increasing numbers of outbreaks within care settings, in particular hospitals and residential care homes (RCH), a decision was made to set up sub groups of the IMT to enable an appropriate focus and expertise to be provided to these two important settings. Both the hospital IMT and RCH IMT meet three times a week and are chaired by the Executive Director of Public Health.
Two cases studies are included in appendix 2 to illustrate just some of the incidents responded to by the IMT.

In summary, the Powys IMT operates in accordance with the requirements of *The Communicable Disease Outbreak Plan for Wales* (2020). It reports internally to the Powys Prevention and Response Group, and externally to Welsh Government. It meets regularly, it has access to real time surveillance data, and it has responded to a number of outbreaks in the course of the pandemic.

NEXT STEPS:

The IMT will continue to meet in its current format whilst there is a need and requirement to respond to outbreaks and incidents.

The IMT will continue to monitor its effectiveness in the early identification of incidents, timeliness and evidence based response and impact on spread and prevalence.

The IMT will be supported in this aim by external feedback from peers, including health protection colleagues from PHW and external review by Welsh Government.

Powys COVID-19 Incident Management Team

Terms of Reference

Legislation and principles of engagement

Local authorities (including port health authorities where appropriate), and Public Health Wales have the statutory responsibilities for the protection of people against specific health threats. The health protection powers are contained within legislation including the Public Health (Control of Disease) Act 1984 (as amended) together with the Health Protection (Local Authority Powers) (Wales) Regulations 2010 and the Health Protection (Part 2A Orders) (Wales) Regulations 2010.

Other organisations will be involved during a health protection incident, depending on the circumstances and scale. Locally, these include NHS Health Boards, ambulance services, police constabularies and fire and rescue services.

The principles of engagement as set out in The Communicable Disease Outbreak Plan for Wales (2020) are that responsibility for managing outbreaks is shared by all the organisations who are members of the Incident/Outbreak Control Team, that decisions are collectively owned, and that individual organisations are responsible for carrying out the actions assigned to them. The plan does not confer on any organisation any additional accountability for the oversight of the actions of other organisations, and does not affect any pre-existing oversight arrangements. Each organisation is accountable for their own response and actions, and should have their own governance arrangements in place to ensure this.

Aim

The primary aim of the Incident Management Team (IMT) is to protect public health by identifying the source and/or main determinants of the outbreak, and implementing necessary measures to prevent further spread or recurrence of the infection. The protection of public health takes priority over all other considerations and this must be understood by all

members of the IMT. The secondary aim is to improve surveillance, refine outbreak management and learn lessons to improve communicable disease control for the future.

Terms of Reference

- To investigate the source and cause of the outbreak.
- To develop and review at each meeting the case definition for the outbreak/incident.
- To maintain an accurate record of cases, control measures, actions and interventions.
- Agree and co-ordinate decisions on the investigation and control of the outbreak ensuring that individuals with assigned individual responsibilities within the outbreak policy execute their roles.
- To identify the population at risk.
- To identify the nature, vehicle and source of infection by using microbiological, epidemiological and environmental health expertise.
- To review evidence of the outbreak/incident and the results of epidemiological and microbiological investigations including data collection and analysis.
- To monitor the effectiveness of infection prevention and control measures and other interventions.
- To escalate any concerns about resource and other issues to the appropriate agencies.
- To manage the communication between relevant agencies and those with a legitimate interest in the outbreak, including Welsh Government, PHW, other Health Boards, general public and media if required.
- To review and update communications at each meeting as required.
- To identify and utilise any opportunities for the acquisition of knowledge about communicable disease control.
- To define the end of the outbreak.
- To evaluate the lessons learned and prepare a final outbreak report with recommendations for the Health Board/Trust and Welsh Government.

Membership

Director of Public Health (PTHB)	Chair
Deputy Director of Public Health (PHW)	Deputy chair
CCDC/Consultant in Health Protection (PHW)	
Public Health Consultant(s) (PHW)	

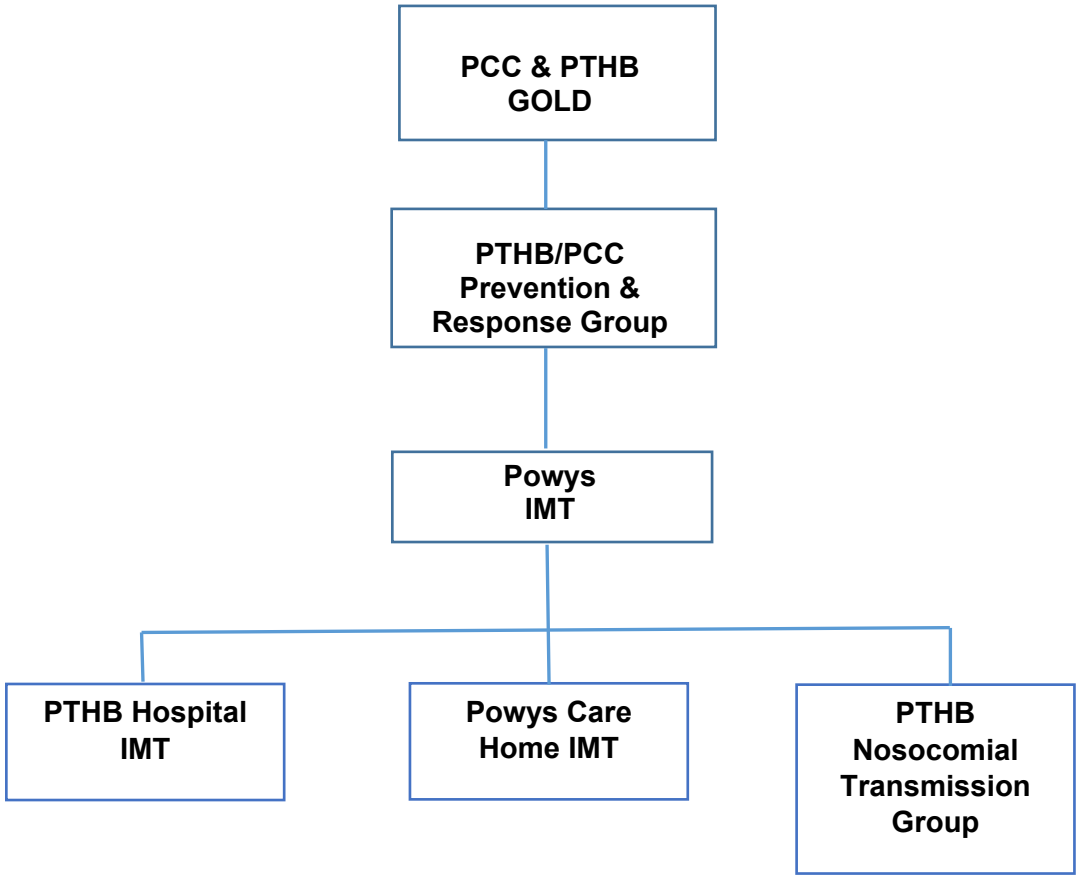
Head of Planning, Property & Public Protection (PCC)	
Environmental Health Officer(s) (PCC)	
Communications Team (PTHB/PCC)	
COVID-19 Contact Tracing Operational Manager (PCC)	
COVID-19 Testing Operations Business Manager (PTHB)	
PTHB Deputy Director of Nursing (Nosocomial Transmission Group only)	
PTHB Infection Prevention and Control	
Military Liaison Officer (PTHB)	
Adult Social Services (PCC)	
Dyfed Powys Police Representative	
Admin support (PTHB)	Notes
Other representatives as required depending on the nature of the outbreak/incident eg: • Education Officers • Civil Contingency Co-ordinator • Food Standard Agency • Representatives from other IMT's/LAs	

Governance

The core members regardless of incident are:

- Director of Public Protection (or their nominated officer of sufficient seniority)
- Consultant in Communicable Disease Control or Consultant in Health Protection
- Health Board Clinical Lead for Microbiology
- Executive Director of Public Health of the Health Board (or their nominated officer of sufficient seniority)
- Lead Officer for Communicable Disease of relevant Las

Reporting Structure



Standard Agenda

PART A: GENERAL IMT MEETING

1. Chair's introduction, including terms of reference

2. Minutes and actions from of last meeting

3. Review membership

4. Outbreak résumé and update
4.1 General situation report:
4.1.1 Current 7-day case incidence and positivity rate;
4.1.2 No. new cases in the last 48hrs;
4.1.3 Maps: Distribution of cases in most recent 7-day period and MSOA case rates;

5. Management of outbreak and allocation of responsibilities
5.1 High risk settings (hospitals, schools, workplaces)
5.2 Other incidents/outbreaks
5.3 Any additional control measures

6. Communications
7.1 Issuing information/advice

7. Media arrangements and spokesperson (interviews, press conferences and so on) if any

8. Consider arrangements for enquiries from the public e.g. relatives (the need for a helpline)

9. Items for the SBAR (Attached)

10. For information items

PART B: CARE HOME SPECIFIC IMT

11. Minutes and actions from of last meeting

12. Current list of incidents/outbreaks

13A. New care home incidents/outbreaks

13B. 14-day Testing within Care Homes with outbreaks

- *What is the current leadership position, what are staffing levels like – will these be compromised by current incident.*
- *Is the home engaged, are they will to except advice and support?*
- *Has an IPC or other reviews taken place – what were the findings. (feedback from MDT)*
- *What do we know about the local area, are rates higher than other parts of Powys*
- *Is the care home linked to other community out breaks what is the local intelligence?*
- *Are they complying with the testing schedules?*
- *What is there history in terms of outbreaks.*
- *What is compliance like with flu vaccination and Covid vaccination programmes.*

14. SBAR Summary sheet care home settings (Attached)

15. Any other business

16. Date and time of next meeting: Mon/Weds/Fri

Case studies

- **Case Study 1: North Powys Food Manufacturer**

In late August 2020, the IMT became aware of three cases associated with a food manufacturing plant in North Powys. On backward contact tracing, it became apparent that these three individuals socialised together outside of work. In light of this, and no further concerns found in the wider workforce, a watching brief was maintained.

Thirty six hours later a fourth case was identified associated with the factory but not associated with socialising outside work. The environmental health officer had further discussions with management within the factory to explore social distancing practices and use of PPE.

Immediate actions taken by the IMT were to advise tightening of the use of PPE, to improve social distancing particularly during work breaks and car sharing on journeys to work.

Testing was arranged for twenty four members of the workforce who worked on the same shift and work area of the factory. When the results were received 60% were found to be positive. As it was evident that there was ongoing spread of infection, the decision of the IMT was to extend testing for COVID-19 to the entire workforce within the factory which was just under 300 additional workers. As rates of coronavirus were increasing in the population, a decision was also taken to offer walk-in testing to the local population. Support for mass testing was provided by Welsh Ambulance Service Trust with a mobile site being set up in the centre of town and made available over 3 days. In total just under 600 local people were tested.

The IMT was extended to include Shropshire County Council, the Health and Safety executive, Powys County Council Education and the communications team from PHW. No major issues were found with the factory, although they did tighten up some local practices regarding ways of working and as a result continued to keep the factory open.

Concerns were raised about the risk of transmission to local schools as they were just opening back up again in early September, however there was no secondary spread.

Following mass testing positive cases and contacts isolated in line with guidance and no further cases were identified associated with the factory. Professional relationships with management in the factory were maintained and no further cases have been identified with this factory over the last five months.

Mid Powys Care Home and Community Outbreak

Following admission to hospital, a resident of a local residential care home (RCH) tested positive for COVID-19. As there were no symptomatic residents or staff within the care home, and an earlier risk assessment had not raised any concerns, a decision was made to test everyone in the home. Whilst testing was in progress, the IMT was made aware of a number of children who had tested positive for COVID-19 within the local primary and secondary school. The mother of two of these children worked in this RCH. Following testing, almost 40% of the residents were identified as positive, as well as 5 out of 39 staff.

As a priority, a joint IPC visit was arranged between PTHB and PCC staff. At the visit a number of infection control processes were identified as being inadequate, particularly in relation to hand sanitisation and donning and doffing PPE. Urgent training was arranged for staff.

A second round of testing 7 days after the initial round confirmed that all residents had become positive, together with 11 out of 39 staff.

The RCH is in a small town and information soon started to circulate about the number of cases associated with the RCH and the view that this was causing an increase in community acquired infection particularly linked to the school but also other local work environments. A number of complaints were received from the community regarding practices within the care home.

The IMT felt it was important to ensure they supported the RCH to improve its practices and regain confidence. A number of media statements were issued to raise general awareness of rising levels in the town with the hope of reducing community tension.

The IPC team and IMT continued to work with the home to improve its practices. The home remained closed for six weeks but it has now reopened. Staff and residents have been vaccinated and there have been no further cases of COVID-19 infection.

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Agenda Item 3.6

Experience Quality Safety Committee	**Date of Meeting: 4th February 2021**
Subject:	**Maternity Service Priorities for Powys, informed by the findings of the Ockenden Report, Maternity Services at Shrewsbury & Telford NHS Trust and the Health Inspectorate Wales National Report for Maternity services**
Approved and Presented by:	Alison Davies, Executive Director of Nursing and Midwifery
Prepared by:	Julie Richards, Head of Midwifery and Sexual Health Clare Lines, Assistant Director for Commissioning
Other Committees and meetings considered at:	• Women and Children's Senior Clinical Leadership Team 28th January 2021 • Midwifery Management and Leadership Governance meeting 2nd February 2020

PURPOSE:

The purpose of this paper is to provide the Experience Quality Safety Committee (EQS) with the emerging findings and recommendations from the Ockenden Report of Maternity services published in December 2020, aligned to the HIW National Report for Maternity Services published January 2021.

The paper provides an overview of the themes and messages that have emerged that inform the key priorities within the developing Powys Maternity Services Improvement Plan and the Assurance Framework for Commissioned Services.

RECOMMENDATION:

The EQS committee is asked to NOTE the report and the careful considerations of the findings and recommendations that will inform the Powys Maternity Improvement Plan and Maternity Commissioned Assurance Framework, to ensure matters being raised are addressed. The Improvement Plan considers the provided midwifery services and the ongoing focus of our commissioner role in relation to the quality, safety and sustainability of maternity services around the borders of Powys.

Approval/Ratification/Decision	**Discussion**	**Information**
	✓	

THE PAPER IS ALIGNED TO THE DELIVERY OF THE FOLLOWING STRATEGIC OBJECTIVES AND HEALTH AND CARE STANDARDS:		
Strategic Objectives:	Focus on Wellbeing	✓
	Provide Early Help and Support	✓
	Tackle the Big Four	✓
	Enable Joined up Care	
	Develop Workforce Futures	
	Promote Innovative Environments	
	Put Digital First	
	Transforming in Partnership	
Health and Care Standards:	Staying Healthy	✓
	Safe Care	✓
	Effective Care	✓
	Dignified Care	✓
	Timely Care	✓
	Individual Care	✓
	Staff and Resources	✓
	Governance, Leadership & Accountability	✓

EXECUTIVE SUMMARY:

Following the review of 250 cases, the first Ockenden Report is intended to bring attention to actions that are believed to need to be urgently implemented to improve the safety of maternity services at The Shrewsbury and Telford Hospital NHS Trust as well as learning recommended to be shared and acted on by maternity services across England. The report has formed Local Actions for Learning and makes early recommendations as Immediate and Essential actions.

DETAILED BACKGROUND AND ASSESSMENT:

1. **The Ockendon Report** articulates the experiences of women and their families who have suffered and those whose lives have been devastated not only by what happened to them and their babies, but also how they were treated offers is strong and powerful message for change.

   The report identifies 27 Local Actions for Learning, framed in four categories: general maternity care, maternal deaths, obstetric anaesthesia and neonatal care. To improve safety in the maternity service at the Trust, the 27 Local Actions for Learning that must be introduced include: greater consultant oversight of maternity care, the appointment of lead obstetricians and midwives with expertise in fetal monitoring and bereavement care to lead on significant improvements; multidisciplinary training and working, ongoing risk assessment for all women, enhanced multidisciplinary and family input into serious

incident investigations, and greater involvement from obstetric anaesthetists when women are complex or become ill.

2. **Powys Teaching Health Board's Maternity Assurance Framework:** it is our intention to work with all commissioned services to ensure the learning from emerging findings Ockenden Report alongside the other reports is adopted, to ensure improvements in the quality and safety of maternity services. It is important that we all work together to ensure the safest, best possible care and support for every woman, every baby and every family. The following approaches for assurance will be undertaken;

Proposed Way Forward in Response to the First Ockenden Report	
A: Assurance in relation to SaTH specific actions	Seek SaTH response to NHSEI letter due by the 15th February 2021.
B: Assurance in relation to actions to be taken by English organisations	PTHB Executive Director of Nursing and Midwifery to send to PTHB English providers – asking to receive a copy of the response which must be submitted to NHSEI by the 15th February2021.
C: Powys self-assessment against Ockenden recommendations	Self-assessment against recommendations by the 15th February 2021 to identify areas where strengthening/equivalent actions may add value e.g. bereavement support, user experience, network, dashboard, governance
D: Welsh Health Board self-assessments	Gather Health Board self-assessments based on WG letter
E: Reporting to Executive Committee and Board Committees and Board	Produce amalgamated position for the PTHB "responsible" population - including further actions needed – for consideration through PTHB Governance structures

In terms of assurance and oversight, internally, we continue to refine the service group governing arrangements and the Powys maternity assurance framework continues to develop, which assists the health board in understanding, and influencing, the quality and safety of the services provided to the women of Powys by neighbouring commissioned HBs and Trusts. The maternity assurance framework along with regular position reports, are provided to the Quality Governance Group and the Experience Quality and Safety Committee, both in the public domain and in-committee where there is a risk of personally identifiable information being placed in the public domain.

3. Powys Provided Maternity Service Self-Assessment

On receipt of the Ockendon Report, Powys Midwifery Management and Leadership team have taken time to review the "Local Actions for Learning" (Chapter 4) and developed the attached "map and gap" template to review all actions and existing improvement plans alongside the requirements of the HIW National Review and the all Wales Maternity

Vision. It is intended to then populate a single, unified Powys Maternity Improvement Plan, enabling a comprehensive approach to the Ockenden Report, the Cwm Taf Morgannwg RCOG and RCM Reports and the HIW National Review of Maternity Service report. The monitoring and progress of the improvement plan will inform part of the Welsh Government Maternity Performance Board which has been delayed due to COVID19 service pressures until late Spring 2021.

The following actions for Ockenden and aligned areas with HIW National Maternity report recommendations are in progress as follows:

3.1 Governance: The Ockenden Report and HIW National Report for Maternity services highlights the importance of maternity department clinical governance structure and team must be appropriately resourced so that investigations of all cases with adverse outcomes take place in a timely manner. Aligned with the Health Board's Quality Governance Framework, Powys Maternity services have strengthened the governance components which have been shared with the EQS committee in December 2020. The Women and Children's Governance Framework includes a serious incident, complaints and concerns group which is meeting monthly to improve the quality and timeliness of investigation and concerns responses.

The Ockenden report is clear in the requirement for neighbouring trusts and Maternity must work together with immediate effect to ensure that local investigations into all serious incidents are declared within their maternity services are subject to external oversight by trusts / health boards working together. Through Quarterly Director of Midwifery and Head of Midwifery meetings an agreed Memorandum of Understanding has been drafted. The all Wales Maternity and Neonatal network has initiated shared learning events across health boards which are multi-professional and encompass maternity and neonatal services.

3.2 Listening to Family Voices: It is vital to ensure that the needs and concerns of women are listened to, respected and acted on. As part of the Quality Governance Framework, Women's and Children's services strengthened the people's experience forum with a co-production approach to strong user engagement. The Women and Children's terms of reference for the PTHB's Women and Childrens People's Experience Forum, illustrates how the directorate will contribute to the implementation of the Powys People's Experience Strategy 2020-23.

The Membership and workplan for the forum include the active and meaningful Powys Maternity and Parent Voices Partnership. Powys service user engagement focus includes increasing the use of Tros Gynal advocacy, Community Health Council support and links with PAVO third sector children and young person representative. The Powys Maternity Improvement Plan and Commissioning Assurance

Framework aim to ensure that experience is considered as part of the commissioned service: Maternity Voices Partnership.

3.3 Multi-disciplinary working: Multi-disciplinary training has been mandated through a Welsh Health Circular and has been fully implemented across all health boards since January 2019. Powys midwifery update training uses the PROMPT methodology which includes the importance of respectful team working to build a supportive work culture. The Ockenden Report highlights the importance of teams training together not simply staying in their professional corners. The Powys Improvement Plan will consider the sense of partnerships need to extend beyond Trusts and Board boundaries

As part of the full implementation of Continuity of Care for Powys Maternity services, each individual team is keen to establish a dedicated Obstetrician linked to each community team to ensure consistency with medical engagement for women with additional needs for pregnancies requiring obstetric input.

3.4 Risk Assessment throughout pregnancy: All Powys women are formally risk assessed at every antenatal contact, so that they have access to care from the most appropriately trained professional in the most appropriate setting for their individual needs. The all Wales pregnancy notes enable women to share information with her named midwife to determine her pathway of care, either midwifery / consultant led. There is an expectation that all professionals will continue risk assessment at each subsequent visit and at the start of labour. Referrals will be made to the appropriate professional when required. Transfers in labour from midwife led services are all reviewed for appropriateness.
At the moment all systems for Powys are paper based and a number of commissioned Maternity services are developing Electronic records and databases. SaTH and Wye Valley have confirmed their intention to implement Badgernet as their preferred electronic record. The all Wales Maternity and Neonatal Network Safe and Effective work stream is developing this model further to encompass the development of an All Wales dashboard and the future Maternity Information System.

3.5 Managing Complex Pregnancy: Welsh Government's response to the Ockenden Report recognises the need for development of maternal medicine specialist centres within regions as an urgent national priority. There must be early involvement of and discussion with specialist centres for women with complex medical issues. The Future Vision for Maternity Care highlighted the need for continuity throughout low risk and complex care, with shared decision making and collaborative working across specialities. Locally Powys and SaTH are jointly developing an agreed pathway for managing complex pregnancy with women who require input from obstetricians will be referred, which conditions this would include and expectations around communication between services. The

specific pathways drawn up in terms of referral processes and communication either way and is based on work through the South Powys Maternity programme. It is anticipated that the agreed pathways will be replicate all of the commissioned services.

3.6 Bereavement Care: The Ockenden Report highlights the provision of support following a bereavement makes a significant difference to the family and how well they feel. Women and Children's team have established a local bereavement network to help support with the quality and compassionate bereavement support offered to families. The work is linked with Health Board Bereavement service improvements. The work plan for the network stemmed from bereavement training which was provided to Powys Midwives and Health Visitors in 2019 by SANDS (Stillbirth and Neonatal Death Society) to ensure high quality bereavement care around sensitive and effective communication. During 2021, there is plan for further SANDS bereavement training, links with the all Wales Maternity and Neonatal network for the implementation of the National (all Wales) Bereavement pathway.

Next Steps

Our aim is to continue to ensure that women, their partners and babies have a positive experience whether in Powys or across our borders.

- To maintain oversight and escalation of commissioned services through PTHB Commissioning Assurance Framework (CAF), to continue to strengthen data gathering and intelligence reporting to provide assurance and be confident about the quality and safety of services for the Powys population.

- As previously presented to the Experience, Quality and Safety committee we will continue with monitoring quality, safety and sustainability of maternity services around Powys' border using our Strategic Change Situation Report and Fragile Services Log, alongside our monitoring of commissioned services compliance to national standards particularly for consultant-led/obstetric care, to ensure strategic oversight of service providers.

- To provide EQS committee progress a future update from the recent publication of National report and recommendations Healthcare Inspectorate Wales review of Maternity services which is intended to provide public assurance and help to improve services for patients and their families.