Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Maternity Unit, Singleton Hospital, Swansea Bay University Health Board

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Singleton Hospital, Swansea Bay University Health Board on 5 – 7 September 2023. The following hospital wards were reviewed during this inspection:

- Ward 20 - a postnatal (following delivery) ward with a capacity of 25 beds including 7 transitional care beds, established for 23 beds
- Ward 19 - an antenatal (before delivery) ward with a capacity of 16 beds
- Antenatal Assessment Unit (AAU) with a capacity of 4 beds
- Labour ward (including bereavement room and birthing pool rooms) 10 beds
- Bay Birthing Unit, Midwifery led unit with a capacity of 3 beds with 2 birthing pools
- Low Dependency Unit - 3 beds
- High Dependency Unit - 2 beds.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 353 paper and online questionnaires were completed by women and birthing people or their carers and 122 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

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

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
We found that staff worked hard to provide women and birthing people, and their families, with a positive experience despite the sustained pressures on the department. Staff were observed providing kind and respectful care, and people we spoke to were generally positive of the care they received from staff. However, some raised concerns about staff availability, delays and sufficient support.

This is what we recommend the service can improve:

- Provide pregnancy related public health information and links to information that is current, accessible in different languages and updated with the latest guidance and information
- Ensure appropriate breastfeeding support is available
- Ensure there is a robust system for the reporting and resolution of Estates faults and improvements needed within the environment
- Review the physical layout/footprint of the unit, including the location of the bereavement room, and layout of the Bay Birthing Unit, to better meet the needs of the service users
- Ensure that appropriate pain relief is given in a timely manner
- Review patient flow and patient experience, especially for those women and birthing people going through the induction of labour process
- Further work is required to support the communication needs for those whom English or Welsh is not their first language
- Engage with people from diverse backgrounds and those with protected characteristics to gauge their feedback on maternity services, to ensure that service provision is appropriate to their needs.

This is what the service did well:

- The majority of women and birthing people, and their families, told us they felt well cared for
- The elective caesarean section process received positive feedback from women that experience it
- The bereavement service was seen to be very supportive.

Delivery of Safe and Effective Care

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

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

We noted the efficiency improvements made in relation to the recruitment of a transformation midwife, digital midwife and changes to the maternity care assistant role. Some of these that had increased the time available for staff to care for patients.

Immediate assurances:
The following issues were raised in an immediate assurance letter issued following the inspection. Further details of the immediate improvements and remedial actions required are provided in Appendix B:

- HIW was not assured regular checks are being conducted on all equipment in accordance with the health board's policy/requirements to ensure the required equipment is available and suitable to use in the event of a patient emergency
- Communication and handover related to antenatal and intrapartum care were insufficient to enable the planning of safe care for all women and babies
- Ineffective infection prevention and control processes in place in some areas of the unit
- Medical equipment and fluid storage in some areas of the unit was not sufficiently secured.

This is what we recommend the service can improve:

- Increase the frequency on antenatal scanning for fetal growth in line with national guidelines
- Ensure that comprehensive and effective staffing escalation procedures are followed and communicated to all clinical staff. This must include clear guidance of the process to follow when staff identify low staffing levels
- Review the activity, staffing, location and processes related to the Antenatal Assessment Unit to ensure safe and effective care for all women that contact the service
- Review and improve the infection prevention and control measures and layout of the second obstetric theatre.

This is what the service did well:

- Peer led ward audits were viewed as good practice.

Quality of Management and Leadership

Overall summary:
During the inspection we met with leaders across the maternity service that worked well together. We saw that multidisciplinary working appeared effective throughout the unit.

Staff feedback showed the team had experienced sustained periods of pressure. Many staff members we spoke to told us they were exhausted and concerned about the impact of low numbers of midwifery staff on patient safety. The majority of midwifery staff we spoke to told us they were struggling to cope with their workloads and poor working environments and were concerned about their own health and wellbeing. We did note however, staff teams worked hard to support each other in the circumstances. Several staff members mentioned the support, kindness, and compassion that the medical team have provided to midwives in recent months.

We noted that many leadership roles in the department are interim and that there have been some challenges related to a stable leadership team over the last two years. We were told of additional measures in place to support the interim leadership team including peer mentoring and coaching.

Senior leaders shared plans to improve staffing levels and develop roles to meet future demands on the service.

Immediate assurances:
The following issues were raised in an immediate assurance letter issued following the inspection. Further details of the immediate improvements and remedial actions required are provided in Appendix B.

- Sufficient and safe levels of midwifery staffing and skill mix was not secured for all shifts to ensure that safe and effective care could be delivered for patients
- Low levels of mandatory training compliance amongst all staff meant that HIW were not assured that all staff that engaged in the delivery of obstetric care had received the relevant up to date training and skills to provide safe care and treatment to all women and babies in their care
- Insufficient security measures were in place to ensure that babies were kept safe and secure.

This is what we recommend the service can improve:

- Review the interim leadership positions in the department and develop an effective plan to secure a stable and effective leadership team
- Consider necessary action from the less favourable comments and themes in the staff questionnaire
- Ensure the timely update and sharing of all guidelines and policies
- Review the specialist roles and ensure that they are effectively embedded into team and health board structures
- Implement a robust plan to ensure that patient identifiable records and information are secure and confidential waste is disposed of securely.

This is what the service did well:

- Incident training for new staff related to risk and incident reporting
- Good multidisciplinary team working
- Efficiency improvements with innovative new roles.

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

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 353 were completed. Overall, the majority of respondents rated their experience positively, with most rating the service as 'very good' or 'good' (214/353) sharing comments such as:

> *"I had an exceptional treatment during labour in the midwife led centre"*
>
> *"Midwives who cared for me were amazing, but the hospital was very understaffed, and the midwives didn't have a break."*
>
> *"Some individual staff members were great"*
>
> *"The midwife who looked after me after delivering my baby and during surgery and the first night was amazing and I don't know how I would have managed if she hadn't of been there."*
>
> *"I felt that I wasn't listened to"*
>
> *"I think they need to do a lot better with employing more staff as they are short staffed"*

We asked what could be done to improve the service. Comments included the following:

> *"Labour ward was short staffed and not enough beds to accommodate. I had very little time, especially given that my husband missed the labour"*
>
> *"Staff were rude and unwelcoming when arrived and was treated as a nuisance"*
>
> *"I was left in a waiting room alone, having full contractions and in a lot of pain, after being sent to the assessment ward from the labour ward, even though I told them I had escalated fast"*
>
> *"I think they need to do a lot better with employing more staff as they are short staffed"*

"I believe I was not listened to in triage which I believe resulted in me having a c section. I expressed concerns while in triage and was told it was normal which after being moved to labour ward was made aware it was not normal what I was experiencing. The midwives on labour ward were amazing, triage however missed several problems which had an impact on my birth."

The health board needs to reflect on the patient feedback in relation to staffing levels and implement improvements.

Person Centred

Health promotion
We saw some health promotion information displayed throughout the unit, this included information on breastfeeding, safe sleeping and general advice on keeping healthy before during and after pregnancy. This information was mostly in English.

We reviewed the online information for pregnancy from Swansea Bay University health board and noted the links to Public Health Wales information on pregnancy were not working. In addition, we found that there could be some improvements in availability of comprehensive pregnancy health promotion information both online and in paper format to ensure that women and birthing people, and their families, can access information to make healthy changes to increase the chances of a healthy pregnancy and baby.

HIW were told about the challenges related to maintaining and promoting public health for women and families alongside delivering maternity care with critically low staffing levels, whereby clinical care is prioritised.

The health board must ensure that pregnancy related public health information and links are available, and updated with the latest guidance and information for women and birthing people.

The health board must ensure that pregnancy related public health information is available in different languages.

The hospital was a designated no smoking zone, which extended to the use of vapour/e-cigarettes. We saw appropriate information providing smoking cessation support throughout the unit. We were told that there was not a specific maternal smoking cessation / reduction support programme available for pregnant women, however there were options to refer into health board delivered programmes. All

women that we spoke to said that they were asked about their smoking habits and were offered support to stop at every appointment.

We reviewed the UNICEF Baby Friendly Initiative (BFI) information board in the day assessment area. Not all staff and healthcare workers that we spoke with were aware of the unit's Baby Friendly Initiative level of accreditation.

The health board must improve awareness of the UNICEF Baby Friendly Initiative, information and accreditation for women and staff.

The majority of women and birthing people who completed our questionnaire felt that the midwifery team respected their decision on how to feed their baby (260/330). However, fewer felt that support was offered from midwives when it came to actually feeding baby whether it be via bottle or breast (192/330). The comments both during inspection and through the questionnaire were mixed in relation to support for breastfeeding.
Comments included:

> *"Feeding support was awful. I was determined to breastfeed, but had little support to do so. I asked for help in latching baby, 1 midwife stood by the door, didn't even come in the room, and said yes that's fine...."*
>
> *"Little help with breastfeeding"*
>
> *"The help I received to learn how to breastfeed my baby was amazing! Staff were constantly on hand to answer any questions and concerns"*
>
> *"I asked for help breast feeding the first night which they were unable to help with."*

The health board should ensure the appropriate level of breastfeeding support, advice and guidance is provided to all women and birthing people that would like to breastfeed whilst in the maternity unit.

Dignified and respectful care
Most women and birthing people, and families that we spoke to during the inspection, and most questionnaire respondents, felt that staff treated them with dignity and respect (246/353).

Most staff (111/121) that answered the HIW questionnaire confirmed that, in their view, patient privacy and dignity was maintained.

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

We saw women and their families being treated kindly and sensitively throughout the inspection.

Some women we spoke to told us about how short staffed the wards seemed to be, and how busy the midwives and staff were, but most felt that their care was not compromised. These conversations were echoed in the patient questionnaire.

> *"Despite seeing it was busy everywhere, staff were putting on smiles even though rushed off their feet, they were incredible at what they do and nothing was too much of a problem. I had the most amazing experience despite being anxious. That's being thankful for a friendly team who felt like family at a time when I felt most vulnerable. They were lovely to my partner & mum too"*

> *"You can see they are understaffed so I do wish & hope that can be sorted for them as the midwives are incredible and needed so much for that experience of women in childbirth."*

During the inspection, the temperature in the maternity unit was especially hot, due to a heatwave. Many patients and staff commented on the uncomfortable heat, the environment and the lack of ventilation in many ward areas. In addition, the three showers that were in the general bathrooms in antenatal were not working during the inspection. During the course of the inspection, one shower was fixed.

HIW were made aware of challenges with the care environment and layout of the unit which impacted on the delivery of dignified and respectful care. This included ventilation challenges, and the delays in repairs to showers on the antenatal ward.

> *" There needs to be some form of temperature control as the ward was unbearably hot and lots of women waiting for inductions, some waiting a week."*

The health board must implement a robust and effective process to ensure that estates faults and improvements are resolved in a timely manner and to a sufficient standard.

A bereavement room was available on the unit for use in the event of an intrapartum death or a stillbirth. We found that the bereavement room located at

the entrance to the labour ward with patient access through the labour ward. This service would be better placed away from other patient rooms to better support patient privacy and dignity at a very difficult time.

We met the specialist midwife for bereavement and noted that she provided support for bereaved families as well as staff.

The health board should review the current location for the Bereavement room with a view to moving the service to an area away from the entrance to labour ward / ensuring that patient access is not through labour ward.

We reviewed the Bay Birthing Unit (BBU) midwife led unit. We saw the 3 birthing rooms, two with a birthing pool. Rooms are small and may limit opportunities for women to mobilise and partners to support. There is a single resuscitation unit available for the BBU (which is located away from main delivery/labour ward).

The health board should review BBU to ensure that available space is maximised to enable women in labour to move around.

We received many negative comments from women waiting for induction of labour procedure to commence. We were told that these delays were due to low staffing levels. We noted that delay in induction of labour was documented on the health board risk register and was added in April 2021. Comments from patients included:

> *"Inpatient induction on ward 19 paused on several occasions over 5 day period due to staffing levels on labour ward. This was distressing, and the majority of staff lacked empathy and compassion"*
>
> *"The induction process is very overwhelming particularly when it is stop-start and women are in for days with nothing happening and getting no proper sleep/rest as there is constant noise and machines beeping etc.*
>
> *"Doesn't set you up for a positive birth being exhausted and uncomfortable. I understand it's all to do with how busy things are but I feel there must be ways of supporting mothers who are just waiting around."*
>
> *"Staff not available to do induction on few occasions despite being over the 12 days from due date."*

Individualised care

Most women and birthing people we spoke to in the Maternity Unit told us that their choices around their care were respected. Those who chose an elective caesarean section were happy with the choices. The health board had improved the care pathway for this group. Their c-sections are performed in main theatre.

On review of patient records, we saw that discussions around labour birth pain relief and feeding choices were not well documented.

We noted suggested birth plans were not routinely completed in booking records. These should make reference to patients' informed choices for labour and birth.

The health board must ensure that birth plans /choices for labour and birth are routinely recorded in patient notes.

Senior midwives confirmed that, due to staff shortages, the Neath Port Talbot Birth Centre midwife led unit had been closed for some time. The option for women to have their baby at home had also been removed during the staffing shortages. We were told that the removal of home birthing and closure of Neath Port Talbot Birth Centre was a decision taken to ensure that services continuing to be provided remained safe across all maternity services in the health board. We reviewed evidence and documentation that confirmed these services had been subject to health board oversight and were included in the health board risk register.

Timely

Timely care

Some women told us of having to wait for pain relief and general maternity care. We were told that women often experienced delays due to capacity / staffing. Many women commented on delays in the patient questionnaire.

> *"I was in agony unable to walk and my husband was made to wait in the corridor not allowed into the ward until a certain time but no staff were available to help me. I bled all over the bed and floor and had to sit and wait for a staff member to help for ages."*

> *"You could tell the ward was understaffed. I would wait a very long time for someone to come when I buzzed"*

> *"I experience good support from my midwife during the antenatal period and really enjoyed my experience birthing in the midwife-led unit.*
> *However, I had to wait over 8 hours to be taken to theatre to be stitched following a grade 3 perineal tear"*

> *"Pain relief not given when asked made to wait a really long time."*

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

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

The health board should review and improve patient flow and experience, especially for those going through the induction of labour process. The health board must mitigate any risks associated with capacity shortages to ensure that safe and effective patient care is maintained.

Equitable

Communication and language
All staff spoken to could provide examples of catering to additional needs of women and all staff stated they would refer and escalate additional requirements appropriately.

Women and birthing people, and their families, gave a mixed response in relation to communication. Some said that staff listened to them (223/353), and some told us of poor communication and not feeling listened to.

> *"Staff had explained absolutely everything to me and my husband and they even managed to calm my husband down. Cannot fault them at all. They even debriefed me afterwards going through everything"*
>
> *"My birthing midwife was outstanding, I will forever remember her. She was so kind and caring and really listened to me. She saw how distressed I was and went above and beyond for me!"*
>
> *"I'd been through labour before and felt that no-one listened"*
>
> *"I was not listened to throughout my pregnancy and any health concern I had was deemed to be related to pregnancy."*

The health board need to reflect on the less favourable patient comments in relation to communication and listening and consider how the service can be improved.

We received feedback from nine Welsh speaking women. Five stated that they were not actively offered the opportunity to speak Welsh throughout their patient

journey, and three said that they did not feel comfortable using Welsh within the hospital. We reviewed information available to women both on the unit and digitally. We found a limited amount of Welsh language information available on the ward via posters or printed material, however we noted all information online regarding maternity services in Swansea Bay UHB were available in Welsh as well as English.

We met some Welsh speaking staff and were told that all Welsh speakers were identifiable to patients as they have a “Iaith Gwaith” logo on their uniform or name badge.

The health board must improve the active offer of Welsh language care for maternity service users.

We found that the maternity unit was not clearly signposted from the main car park, the main entrance of the hospital, or throughout the hospital buildings. This could make it difficult for people to locate the appropriate place to attend for care and cause a delay to their care. Any signage that was in place had ward numbers rather than ward names or specialities. This was disappointing to see as the previous HIW Maternity inspection for Singleton undertaken in 2019 found the same signposting issue, and it appears the health board has taken no action.

The health board must improve maternity unit signage at the hospital (including from the car park and main entrance) to ensure that the maternity unit it is easy to find for all patients and visitors to the hospital.

We reviewed nine sets of patient records, and none noted language preference. This could make it difficult for those for whom English is not their first language, to communicate effectively. This poses a risk to safe care due to potential miscommunication.

The health board must ensure that patients from non-English / Welsh speaking backgrounds communication needs are met. Language preference must be noted in patient records. All staff should be made aware of importance of translation and communication support and translation services available.

Rights and Equality

We reviewed the health board information online and noted health board specific information and values statement relating to equitable care as well as recruitment.

Most (264/300) women and birthing people said that that had not faced discrimination when accessing or using this health service on grounds of any protected characteristics under the Equality Act (2010). Those patients that said they did face discrimination, did not share any specific examples of discrimination related to protected characteristics.

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

Midwifery leaders confirmed that diversity and equality training was mandatory for all staff, although we did not receive data during the inspection that confirmed compliance levels for this training.

The health board must ensure that equality and diversity training is delivered and attendance monitored.

In addition, we reviewed the Maternity Voices Partnership Annual report 2023 and noted that there is little active engagement with women and families from minority groups and diverse backgrounds, to gain feedback on their experiences of maternity care.

Some staff told us that they knew how to access translation services. We noted however, that there was no hearing loop in place and there was limited information displayed or available online for those from diverse backgrounds accessing maternity care.

The health board must improve engagement with those from diverse backgrounds and those with protected characteristics to gauge their feedback on maternity services to ensure that service provision is appropriate to their needs.

Delivery of Safe and Effective Care

Safe

Risk management
There were some established processes in place to manage and review risks and to maintain health and safety in the hospital. We reviewed the health board risk register dated August 2023. There were four risks related to maternity care that were added two years ago. However, they were still rated red or amber, and had risk target dates in the past.

Maternity risks should be reviewed regularly, and actions should be updated and escalated accordingly to ensure they are progressed and completed in a timely manner.

The health board risk register review also confirmed conversations with staff that there was not enough Ultrasound capacity within the health board to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP). There is a risk to the safety of women, birthing people and babies if national guidance for fetal growth scanning is not followed.

This risk was added to the register in August 2019. Mitigations are noted on the risk assessment, these include improved compliance with GAP Grow training. We noted, however that the GAP Grow mandatory training compliance was consistently low when we inspected in September 2023.

The health board must provide details of plans to mitigate the risks of not following national guidance regarding antenatal scanning for fetal growth as well as plans to increase capacity for scanning.

The issue regarding poor compliance with mandatory training (including GAP Grow) was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

We reviewed an escalation process document which was not dated. We were advised that this document had been ratified through the health board Quality and Safety forum. Some key clinical staff that we spoke to throughout the inspection were not able to define the escalation process or confirm minimum safe staffing levels for the unit. We were told that if the acuity tool that was in use indicated low staffing then they would complete an incident report.

- **The health board must ensure that comprehensive and effective staffing escalation procedures are followed and communicated to all clinical staff. This must include clear guidance of the process to follow when staff identify low staffing levels.**

We reviewed the antenatal assessment unit (AAU) and were told of a number of challenges to deliver safe and effective care in this area.

Staff provided examples of challenges and potential impacts on the delivery of safe care. This included an example (reported via Datix) whereby the AAU midwife was working alone, with responsibility for three patients, all of whom had CTG monitoring in progress. The AAU midwife had to transfer a patient to labour ward, however, on transfer there were no staff available on labour ward to take handover of the patient. The AAU midwife remained with the patient on labour ward for 1hr and 30mins. During which time, a 5min bradycardia was recorded on one of the CTG's that had been left in progress on AAU. This was picked up by a passing member of staff. The bradycardia was later identified as being maternal pulse. Whilst no immediate harm was caused the AAU midwife was concerned that this was a near miss incident. All the staff spoken to on AAU were deeply upset about the impact of low staffing on patient safety.

Specific challenges related to the antenatal assessment unit are:

- The staffing levels for AAU are not included in the unit acuity tool, meaning that they could be experiencing peaks in demand and complexity of cases without these challenges being effectively escalated. We saw documentation, and spoke to staff, that confirmed continued challenges with the low levels of qualified midwifery staff on this unit that this service experienced delays related to assessment of women, sometimes to the extent that midwives feel unsafe. NICE (2015) guidelines state that women presenting at AAU should receive their initial assessment within 30 minutes of presenting. The health board introduced the standard that all women attending AAU should be triaged within 30 minutes of presentation, this was following a serious incident review some years ago. Staff told us that staffing levels on AAU meant that this time target was regularly missed

- The antenatal assessment unit is often where women start their intrapartum care however, there did not appear to be sufficient overview of all women and birthing people entering the service

- The antenatal assessment unit was located on a different floor to labour ward and challenges related to the moving of women between the areas were described whilst continuing to provide safe care to women on AAU

- We saw that there was one direct phone line into AAU, if this line is busy staff could not confirm that additional callers could get through, there was no divert and no queue system in place. There is a risk that someone in need of care, emergency advice, treatment or intervention would be unable to get through to the triage assessment.

- The process for telephone assessment was described and documents reviewed. We noted that usually a non-clinical team member takes the initial call and completes a "Telephone Advice" sheet, if the midwife is busy with a patient then the midwife calls the patient back to complete the telephone triage assessment, usually electronically. The telephone advice sheet is routinely thrown away, the sheets are not scanned or uploaded to the IT system. Due to the many steps, different methods of recording, disposal of information and lack of "join up" for this telephone assessment service HIW are concerned that there is a risk that communication may be missed and / or assessment delayed as a result.

The health board must fully review the activity, staffing, location, and processes related to the Antenatal Assessment Unit to ensure safe and effective care for all women that contact the service.

- **The health board must review the processes related to the staffing of the antenatal assessment unit and ensure that sufficient number and skill mix of staff are in place. The health board must ensure that AAU staff levels are included in the unit acuity tool to minimise risks around staffing on this unit**

- **The health board should ensure that all women in AAU/ Labour ward overseen by labour ward co-ordinator to ensure that front door function/activity is monitored in conjunction with labour ward activity and a safe and effective pathway of care can be ensured for all patients regardless of how they entered the unit**

- **The health board must review with a view to improving the telephone system for women calling AAU for advice to ensure that an effective system is in place for women to speak to a member of staff should the line be busy**

- **The health board must complete a comprehensive review of the telephone assessment process, information recording and sharing to streamline the process and improve safe and effective communication**

- **The health board must perform a full audit of calls versus women seen over a period, including delays to 30-minute target and ensure improvements are implemented**

- **The health board must define and implement a formal process regarding patients that DNA following advice from AAU / Triage to be seen. This needs to be implemented to ensure the safety of women and babies. Furthermore, data related to DNA needs collecting and auditing.**

During the inspection we attended medical handover meetings on 5 and 6 September 2023. We noted that medical handover for intrapartum and antenatal care occurred separately with separate consultants responsible for intrapartum and antenatal care. The intrapartum element of handover was multidisciplinary and educative; however, it did not adequately capture information related to the potential flow of patients into labour ward. It also did not adequately capture all patients undergoing induction of labour, in antenatal assessment or on antenatal ward. There was no evidence of that this took place consistently, although we were informed that the informal discussions took place between the consultant responsible for antennal patients and the consultant responsible for labour ward. We were not assured that medical handover between antenatal and intrapartum patient care was sufficiently effective, routinely recorded and communicated, ensuring that all women across the unit were prioritised effectively and in a timely manner to maximise patient flow and minimise risk of deterioration.

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

We were told that there was a rota for manager on call and executive team member on call.

There were two theatres on the labour ward for obstetric cases. We were informed that elective caesarean section births took place in the main theatre located away from the antenatal and labour wards. The team did not inspect the main theatre during the inspection.

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

We reviewed effective checklists, systems and processes in place in relation to the delivery of safe and effectively theatre based obstetric care. We witnessed

effective multidisciplinary working. We saw that women and their partners were supported and communicated with effectively in theatre.

We saw that there was one obstetric theatre team in residence. We were told that if acuity is high, a second team could be called in from offsite. This poses a potential risk of delay to emergency obstetric care if a second theatre is required for urgent deliveries.

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

The health board must ensure that the processes related to any required second obstetric theatre team have been effectively risk assessed and mitigations implemented to ensure safe, effective and timely emergency obstetric theatre care.

Maternity and Neonatal services are located in Singleton hospital which is geographically located on a different site to critical care, intensive care and emergency department services in Morriston hospital. There is a risk of harm to obstetric patients requiring critical care due to the need for ambulance transfer to another hospital. There is no dedicated obstetric cover at Morriston hospital, therefore patients transferred for critical care services could have delayed obstetric review due to traveling to another site. Patients transferred for critical care services will be separated from their babies due to there being no neonatal cover at Morriston hospital site. We reviewed the risk register entry related to this issue and were advised that there is no safe alternative to this situation at present.

The health board should review the processes and provisions for women and birthing people and their babies, should an ITU transfer for an obstetric patient be necessary.

When we arrived at the maternity unit we saw that one of the lifts was not working. The delivery suite is on Level 5 of the unit and the entrance on Level 1. There is risk that women in labour may experience delays to their care or be unable to reach delivery suite in a timely manner due to repeated lift malfunction.

The health board must ensure that risks of malfunctioning lifts in the maternity unit are mitigated to minimise the risk of delayed care and protect patient dignity.

The inspection team met with key staff members responsible for risk management. Leaders told us that there had been a positive culture change over the last two years around the reporting and learning from incidents. This was confirmed by the staff questionnaire. Most staff said their organisation treats staff who are involved in an error, near miss or incident fairly (82/119). Staff also told us that they were encouraged to report incidents (117/120). Fewer staff (77/120) told us that they are given feedback about changes made in response to reported errors, near misses and incidents.

We reviewed training / induction information that is delivered to staff by the team responsible for risk and incident reporting. It clearly identified the multidisciplinary team responsible, Datix reporting, incident reviews, nationally reportable incidents, support for staff, escalation guidance and where to find shared learning. **This induction information was noted as good practice.**

We saw that there were around 300 open incident reports at the time of inspection. Whilst this represents a significantly higher number than senior leaders would hope for, they shared evidence of regular meetings, systems and processes that were in place to monitor themes and trends and ensure that this information is captured and shared to improve practice. We reviewed an example of immediate dissemination of learning and guidance following a never event that what reported.

We noted effective multidisciplinary team working together in the review of significant events and incident reporting, however also noted that this work was challenging in times of staffing shortages.

There is significant backlog in managing and resolving incidents. This meant that it is likely that learning was not undertaken in a timely and effective way to reduce the risk of reoccurrence.

All staff we spoke to told us that the organisation encourages them to report errors, near misses or incidents. However, some staff said that they rarely receive any formal feedback following incidents which would be a missed opportunity for learning and improvement.

The health board should review the reporting, investigation and management of concerns and clinical incidents with a view to expediting the process and timely sharing of any lessons learned or recommended changes in practice.

Infection, prevention, control (IPC) and decontamination
We found that the most areas of the unit were clean. However, on arrival in the low dependency area of the unit, we observed a blood mark on a trolley, blood soiled waste disposed of in a glass disposal bin and overdue changing of disposable patient curtains, one dated December 2022 and one November 2022. Staff members that we spoke to were unable to confirm when disposable curtains throughout the unit should be changed or the process for changing them.

HIW were not assured effective processes were in place or being followed to prevent healthcare acquired infections.

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

We reviewed some evidence related to cleaning audits for the department. Specifically, we reviewed several "Quality Assurance Framework - Ideal Ward toolkit" audits which had been completed by multidisciplinary teams. **The undertaking of these peer led audits were viewed as good practice**. It was noted that there were some recommendations in relation to IPC from the Ideal Ward Toolkit audits that the inspection team did not see in practice, examples included the lack of room cleaning checklists in each room as well as the routine use of "I am clean" tags for equipment. These findings corresponded with HIW findings.

Inspectors noted that some areas of the unit looked tired and in need general update.

Whilst we saw that hand hygiene audits were completed as part of the Quality Assurance – ideal ward toolkits, we did see clinical staff that were not adhering to the bare below the elbow standard and therefore health board IPC policy. We noted staff wearing watches and rings with stones in clinical areas. We also escalated some concerns during the inspection around uniform. We noted staff wearing leggings, inappropriate footwear and necklaces. These issues were highlighted to leaders throughout the inspection.

The health board must ensure that staff conform with health board IPC requirements for bare below the elbow and uniform.

The health board must implement a full IPC audit and ensure that the IPC audit process is structured, effective, tracked and monitored to drive improvement.

During the inspection we reviewed facilities for storage of placentas. This was in a fridge in the team room. We recommend that this storage is relocated.

The health board must review where placentas are stored and locate them in an appropriate area of the unit.

Safeguarding of children and adults
The health board confirmed the policies and procedures in place to promote the welfare of children and adults that may be at risk. Most staff that we spoke to were aware of these policies and procedures. They were all able to tell inspectors how they would effectively escalate a safeguarding concern.

We noted, at the time of inspection, that mandatory Safeguarding training rates could not be confirmed.

The issue of mandatory training was dealt with under HIW's immediate assurance process and are referred to in Appendix B of this report.

We reviewed a document with feedback from a baby abduction drill that took place on 19 October 2022 which detailed actions and learning from the drill. The inspection team considered the security of newborn babies in the maternity unit and noted risks present. These are raised with the health board separately to this report and the health board have agreed actions to address and resolve risks.

This, along with the midwifery staff shortages across the unit meant that HIW were not assured the unit was sufficiently protected to minimise the risk of baby abduction.

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

We noted that there were some specialist roles in post to support some women and families with additional requirements. For example, there was a safeguarding midwife and mental health midwife in post.

Midwives told us that they used standard guidelines to assess maternal mental health and we saw evidence of this in the patient records that we reviewed.

Blood management
We saw that there were appropriate systems in place to ensure safe blood management and transfusion 24/7.

This included use of the All-Wales transfusion record, appropriate storage and handling of blood products, and appropriate training for staff relating to the administration and monitoring of patients.

We were told that blood testing is centralised at Morriston hospital and the sending of patient bloods to another hospital for testing can cause delays around clinical decision making and care for obstetric patients.

The health board must audit delays in blood results for obstetric patients and mitigate risks of potential patient harm as a result of any delays.

Management of medical devices and equipment

We reviewed the checks related to medical devices and equipment to ensure that all equipment including resuscitaires and defibrillators were working effectively and safe to use in the event of a medical emergency. We saw that these checks were not recorded every day. Emergency equipment checking was inconsistently performed throughout the unit and checking logs were stored away from the equipment. On postnatal ward whilst we saw that the emergency resuscitation trolley was well organised and checked, there was no check log for one defibrillator. However, this was addressed during the inspection and one was generated and in use during the inspection.

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

Staff told us of the process for servicing and repairing equipment seen, however no formal process documentation or asset register were seen on inspection to ensure that processes were in place to ensure that equipment effectively serviced and calibrated.

The health board must ensure appropriate asset register log in place with formal processes in place for servicing and repair.

During the inspection, we saw two storage cupboards with keypad access storing fluids and medical equipment were latched open with access codes written on stickers on the doors. The cupboards were located on the main corridor to the unit with access available for any visitor, patient or unauthorised member of staff. HIW were not assured fluids and medical equipment on the maternity unit were suitably stored to reduce the risk of unauthorised access. This poses a potential risk to the safety and wellbeing of patients and other individuals who may access, tamper with and / or ingest medication not meant for them. This issue was escalated during the inspection and the cupboards were secured and codes removed.

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

On checking of some routine equipment, we noted that some needles on a trolley in postnatal ward for use were out of date. These were escalated and removed at the time of inspection.

The health board must provide assurance of a robust system in place to ensure that out of date equipment is safely removed from the clinical area.

Medicines Management

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

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

Controlled drugs processes were reviewed and seen to be effective.

Effective

Nutrition and hydration

We observed the serving of a lunchtime meal and the food looked appetising and was served promptly. Women and birthing people told us there was choice available. Organisation and coordination around the mealtime was efficient. Staff on the wards had access to facilities to make food and drinks for patients outside of core hours and there is a trolley service available for hot meals where patients can pre-order food. We saw a choice of menus, hot and cold. We noted that sandwiches and water were readily available.

Patient records

We reviewed nine sets of patient records as part of the inspection. The results of our review were mixed. We saw that risk assessments and care plans were routinely completed at booking. We saw most records included clear accountability and evidence of how decisions were made.

Entries in all records were not always signed with legible signatures or names written in capitals to enable follow up with an individual staff member if necessary. Good practice would be to stamp the entries.

We saw that cardiotocography (CTG) traces were not available in records however we were informed that these were available electronically.

One set of notes we reviewed were incomplete and some note entries were illegible. In these records it showed that the patient experienced delays in being reviewed by a clinician despite her contractions getting stronger.

On review of patient records, we saw that pain relief discussions were not routinely documented with women. Patient records did document when pain relief was requested but not the pain relief options discussed.

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

Quality of Management and Leadership

Staff feedback

HIW issued a questionnaire to obtain staff views on the maternity services provided at Singleton Hospital and their experience of working there.

In total, we received 122 responses from staff. Some questions were skipped by some respondents.

Responses from staff were generally negative, with half being satisfied with the quality of care and support they give to patients (61/121), less than half agreeing that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (46/121), and fewer recommending their organisation as a place to work (37/121).

Professional development

Many staff felt that they had appropriate training to undertake their role (73/121). We received a number of comments on training:

> *"Due to staffing acuity, I have been taken off mandatory study days to aid staffing in the unit instead and this has resulted being out of compliance in some training for 2 years now which I have informed management of but no action has taken place yet."*

> *"Mostly learning through experience rather than specific training."*

Patient care

Less than half said they have adequate materials, supplies and equipment to do their work (51/121). Hardly any felt there are enough staff for them to do their job properly (3/122). Most thought patients' privacy and dignity is maintained (111/121).

Some comments we received about patient care are below:

> *"The unit is incredibly short staffed at present."*

> *"Staff here look after each other and support one and other, it is as a whole a great place to work. But due to staffing crisis it can be worrying and overwhelming."*

> *"Morale is the lowest I have ever known it to be."*

> *"More staff is needed to meet the demands of the service. We have a much more populated area and not bigger hospitals or staff numbers to cope with the demand."*

"Staffing is at crisis point- there is poor staff retention. Staff are burnt out and patient care is left compromised in that it is rushed and not finished due to needed to be pulled from pillar to post. Staff rarely get a break on shifts and no senior management come to offer to relieve staff."

Equality
Six respondents told us that they have been discriminated against based on a number of factors and 13 respondents told us that not all staff have fair and equal access to workplace opportunities.

Staff feedback through the staff questionnaire as well as feedback that was received during the inspection, represented a staff team that had experienced sustained periods of pressure. Many staff members that we spoke to told us they were exhausted and concerned about the impact of low numbers of midwifery staff on patient safety as well as their own mental health and wellbeing. The majority of midwifery staff that we spoke to told us they were struggling to cope with their workloads and poor working environments.

We saw very low morale in the midwifery team. We did note however staff teams worked hard to support each other in very difficult circumstances. Several staff members mentioned the support, kindness and compassion that the medical team have provided to midwives in recent months.

Leadership

Governance and Leadership
We observed that several key positions within the leadership structure were occupied on interim basis and sometimes for than 12 months. This did not allow for longer term goal setting, development of a clear vision and the ability to instigate changes needed for the advancement of the service.

It was encouraging to see that there were schemes and mentoring in place to support and develop new leaders. Most midwifery leaders told us that they felt supported in their roles.

The health board must review the interim leadership position in the department and develop an effective plan to secure a stable and effective leadership team.

Due to significant changes in management structure over last 12 months it was difficult to establish the clear lines of reporting and accountability. Core leadership structures were interim and organisational structure could be produced.

We did however meet with dedicated and supportive leaders that are attempting to stabilise and improve the service after many changes in leadership.

The health board must update and share an organisation chart with key people and roles identified.

Staff told us that senior leaders are not always visible and most staff we spoke to were not assured that escalation was taken seriously.

This was confirmed by responses in the staff questionnaire which stated that most (89/122) staff felt that the senior management were not visible and also that communication between senior management and staff is not effective (97/120).

Many staff members that we spoke to felt disillusioned undervalued and disconnected with the overall leadership at the health board, some stated that they felt let down.

The health board must consider and act on all themes and comments from our staff survey.

Some doctors told us that the culture in the medical team is good. Many told us that doctors in training feel well supported and many return to the unit after training.

At the time of inspection, we reviewed evidence detailing 158 obstetric guidelines for the department that were uploaded to the health board system (WISDOM.) Of those, 52 were identified as being out of date.

The health board must develop a robust plan to ensure the timely update and sharing of all guidelines and policies.

We reviewed evidence of regular meetings that take place these are minuted with actions that are dated and follow up on themes from practice. These included labour ward forum minutes, Quality and Safety minutes. We were told that this information is shared with wider teams.

Workforce

Skilled and Enabled Workforce

Throughout the inspection we witnessed staff members working well as a team. We noted examples of effective multidisciplinary working and saw staff at all levels working to attempt to find innovative solutions in sometimes exceptionally

difficult circumstances. Many midwives and doctors that we spoke to were complementary of their team colleagues and the staff questionnaire found that most staff members (93/121) agreed that their immediate line manager could be counted on to help with a difficult task.

During our inspection we requested details of mandatory staff training. From the information provided we identified poor compliance with mandatory training from all specialities (Doctors and Midwives). We received an overview of mandatory training compliance rates for September 2023 which detailed overall percentages of compliance with mandatory training via department. Individual course compliance information was not readily available for every department and generic percentage compliance rates were submitted. The compliance rates for mandatory training were below 70% for most training courses. We received further evidence confirming low compliance with mandatory Gap and Grow training within the midwifery team. The information showed that 67% of midwives had completed Gap and Grow training in the last 12 months. No evidence was received from medical team.

This meant that HIW were not assured that all staff that engaged in the delivery of Obstetric care had received the relevant up to date training and skills to provide safe care and treatment to all women and babies in their care.

> *"Due to staffing acuity, I have been taken off mandatory study days to aid staffing in the unit instead and this has resulted being out of compliance in some training"*

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

During the inspection, our team noted that midwives on the unit are not routinely trained in cannulation. Student midwives now qualify with cannulation training, however, any newly qualified midwives will be unable to consolidate their canulation training as there are no midwifery staff to observe. Therefore, there is a risk of deskilling.

The health board must review the midwifery training skills and competencies and ensure that options are in place for consolidation of training.

Singleton Maternity Unit has experienced a sustained period of low levels of midwifery staffing. On review of the health board wide statistics, the maternity unit was logged to have not reached Birthrate Plus staffing levels since 2019. Senior staff confirmed during inspection that the low levels of staffing for

maternity unit was rated at the highest possible level on the health board risk register.

During the course of the inspection, we noted that there was consistently lower than Birthrate plus required midwives available to support the unit and women and birthing people. On the first evening of the inspection there were 11 midwives on shift (including the labour ward lead). Birthrate plus levels for midwifery staff were confirmed as 13 or 14 if labour ward lead included.

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

We reviewed multiple sources of evidence relating to mitigating the risks of low staffing levels (especially in midwifery staffing). This included daily escalation meetings whereby senior midwifery team and group service director had a snapshot of what was happening in the unit. We also saw the development of a midwifery bank, use of agency staff, band 8 midwives being called in to work clinically and forward booking of midwives to cover gaps. We reviewed information, reports and evidence related to Organisation Change Processes that were ongoing.

Due to consistently low staffing levels, we were not assured that staff would be able to recognise and provide a timely response to emerging patient risk.

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

Staff questionnaire responses indicated that most staff were concerned about the risks of running a maternity service with consistently fewer than establishment required staff levels. Hardly any (3/122) felt that there were enough staff for them to do their job properly. Most staff (94/121) said that they were unable to meet all of the conflicting demands on their time at work.

Comments included

> *"The unit is incredibly short staffed at present."*
>
> *"Staffing is at crisis point- there is poor staff retention. Staff are burnt out and patient care is left compromised in that it is rushed and not finished due to needed to be pulled from pillar to post. Staff rarely get a break on shifts and no senior management come to offer to relieve staff."*

> *"Staff here look after each other and support one and other, it is as a whole a great place to work. But due to staffing crisis it can be worrying and overwhelming."*

Many staff told us that the risks of low staffing had been maintained for a sustained period of time and in our questionnaire most (92/121) disagreed that the hospital takes swift action to improve when necessary.

The health board must consider the feedback from the staff questionnaire and consider how improvements can be made to better support staff.

The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.

We reviewed staff rotas and confirmed that during the 14 day period prior to inspection, 11 days had midwifery staffing below the establishment requirement. (a requirement of 13 or 14 if including the Band 7 coordinator).

In addition, on 7 September 2023 we were told that only nine midwives were confirmed for the night shift.

HIW were not assured that sufficient midwifery staffing and skill mix was routinely secured for shifts to ensure that safe and effective care could be delivered for patients.

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

During the inspection we were informed that 21 new midwifery staff had been recruited and were due to start before December 2023. We saw evidence of effective training and induction plans in place.

We reviewed training and learning events that had been delivered by the Clinical Supervisors for Midwives team and saw some evidence of themes from incidents and events as well as wider learning themes being covered.

The inspection team saw a wide range of specialist midwife roles (including safeguarding, clinical governance, public health, mental health) were in place. Some of these roles are relatively new and not fully embedded. These roles were often individuals that, during periods of absence, did not receive substantial cover. Not all staff were aware of the roles of these specialist midwives.

The health board must review the specialist roles and ensure that they are effectively embedded into team and health board structures.

Culture

People engagement, feedback and learning
On all wards within the department, we saw QR codes on posters with details of how to feedback about care. We saw Putting Things Right information available bilingually as well as leaflets on how to make a complaint.

We saw an engaging feedback board comments display written by women on wall in antenatal corridor. This feedback was all positive. We also noted feedback displayed in the Bay Birthing Unit. We reviewed a "you said we did" board with details of changes that had been made as a result of patient feedback.

We reviewed reports and information from the health board Maternity voices group these regularly detailed satisfaction rates for women and birthing people.

Most staff 91/122 confirmed that patient feedback is collected within maternity services, more than half (68/122) said that they did not receive regular updated on patient experience.

We reviewed complaints logs and timelines to show the progress of complaints received by the health board.

The health board must ensure that patient feedback is routinely fed back to staff.

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

Most staff (101/121) told us that they knew how to report concerns, although fewer (76/121) told us that they felt secure raising concerns about unsafe clinical practice.
The health board must ensure that systems and processes are in place and communicated whereby staff feel secure to raise concerns about unsafe clinical practice.

Information

Information governance and digital technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018 within the unit.

Whilst we saw some evidence of patient information being stored securely, we noted occasions when this was not the case. On our arrival at the Maternity Unit, we saw patient notes were on a windowsill and a notes trolley in the team room with the door propped open. We also saw that there was confidential patient identifiable data in a normal, open top bin outside low dependency. Inspectors advised staff to speak to information governance colleagues to obtain appropriate confidential waste bins. We were not assured that patient confidentiality was adhered to and patient information was store and disposed of in line with GDPR requirements.

The health board must implement a robust plan to ensure that patient identifiable records and information are secure and confidential waste is disposed of securely.

Learning, improvement and research

Quality improvement activities

The department medical staff team told us that medical research was a priority for the unit. Examples of obstetric research projects included projects related to pre-eclampsia, cholestasis, fetal fibronectin and the Big Baby Trial.

We were told of organisation change proposals that were in progress across the department in an attempt to stabilise the safe staffing of the unit. We received many negative comments on areas of this change proposal from staff members.

We noted that the maternity care assistant role remit at Singleton has been extended to support the midwives with non-midwifery tasks to release midwifery time to care. We were told that this offered opportunities for development for these maternity care assistants. We also noted that a Maternity Transformation Midwife and Digital midwife have recently been appointed to work towards quality improvements and efficiency savings.

4. Next steps

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

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

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Concerns identified during the course of the inspection noted in Appendix B and C			

Appendix B – Immediate improvement plan

Service: Maternity Unit, Singleton Hospital, Swansea Bay University Health Board

Date of inspection: 5 – 7 September 2023

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

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
Findings **Midwifery staffing levels** We reviewed staff rotas and confirmed that during the 14 day period prior to inspection, 11 days had midwifery staffing below the establishment requirement. (Requirement of 13 or 14 if including the Band 7 coordinator). In addition, on 7 September 2023 we were told that only 9 midwives were confirmed for the night shift. HIW were not assured that sufficient midwifery staffing and skill mix was routinely secured for shifts to ensure that safe and effective care could be delivered for patients.				
1. The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of		Daily Staffing Escalation Meetings continue Chaired by the HoM to overview daily staffing and monitoring of quality, safety and any harm events.	Service Group Director and Service Group Nurse Director	Commenced 11.09.23 with continuous monitoring

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
suitably qualified and trained staff on every shift within the maternity service.		This includes oversight of staffing levels over a rolling 8 week plan to utilise all options open to the Health Board to ensure these numbers are maintained and mitigate as required. This will include Non-Framework Agency and Enhanced Overtime, and will be monitored by Service Group Director led staffing meetings supported by the maternity team.	As above	
		Format of meeting to include risk mitigation and escalation of risk to the Service Group Directors in the first instance using the risk management, and quality governance processes, and escalation to the Executive Team as required.	As above	Format changed 18.9.23
		Feedback to staff via weekly open forums with Director attendance to keep them updated on actions being taken to keep service safe and staffed.	Head of Midwifery /Deputy Head of Midwifery	22.9.23 Commenced

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		Health Board Risk Register (ID 2788) outlining controls and mitigation:- • Continued suspension of Home Birth service and Free Standing Birth Unit to support safe staffing in line with RCOG Guidelines • Escalation plan deploying Specialist midwives, ward managers, Band 8a Lead Midwives and Matron to support safe staffing when required • Forward booking plan for midwifery bank and agency midwives, all shifts requested until 18th November 2023 • Nurse Bank actively engaged with contract Agencies to secure block booking options • Obstetric Unit and Community midwives Staff OT (A4C OT rates) offered	Service Group Director and Service Group Nurse Director	Review fortnightly with continuous monitoring (Commenced & ongoing)

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		• All part time clinical staff have been offered to increase in hours • Service Group Roster scrutiny process continues in relation to oversight of effective rostering against KPI's • Sickness management in line with the Managing Attendance at Work policy. Impact of change workshops held. Further support being considered around additional staff wellbeing and absence. This is under discussion with the HR Team. • Regular HOM meetings (fortnightly) with Director of RCM Ensuring Maternity Voices Partnership (MVP) and Llais are updated.	Head of Midwifery SBU Human Resources via Central Recruitment Team SBU Human Resources	MVP: 25.9.23 LLais: Next Scheduled Meeting Completed 11.9.23 with continuous monitoring Completed 11.9.23

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		Expediting pre employment checks for cohort of newly recruited midwives via the Central Recruitment Team who are due to start employment in October/November 2023 (21.8 WTE)	Head of Midwifery & Human Resources Matron	31.10.23 New Advert planned W/C 18.9.23 Complete
		Long term sickness management in line with Attendance at Work Policy reviewed by Work Force Team week commencing 11.09.23 who have confirmed compliance with policy. Further action has been expedited by Work Force Team.	Workforce Transformation Midwife	Training completion date 31 July 2024
		Wellbeing strategy to be refreshed with support from Human Resources and Organisational Development. Proactive recruitment campaign and rolling recruitment for Midwifery Bank.	Service Group Directors, but lead by the Head of Midwifery	Implementation projected end of January 2024 depending on outcome of consultation

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		Workforce Transformation Midwife supporting training and development of Maternity Care Assistants to maximise skill mix opportunities and workforce capacity. Currently 11 in training providing service cover with full completion of training and competencies by July 2024 2 Organisational Change Processes (OCP) currently progressing in line with Maternity Transformation work to maximise workforce capacity. Obstetric Unit OCP Commenced 10.7.23 Community OCP commenced 11.9.23		

Findings

Mandatory training compliance

During our inspection we requested details of mandatory staff training. From the information provided we identified poor compliance with mandatory training from all specialities (Doctors and Midwives). We received an overview of mandatory training compliance rates for September 2023 which detailed overall percentages of compliance with mandatory training via department

(cost centre). Individual course compliance information was not readily available for every department and generic percentage compliance rates were submitted. The compliance rates were as follows for mandatory training:

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe | Swansea Bay University Health Board

Neath Port Talbot & Singleton Service Group

Women's Health & Ophthalmology Division

Mandatory Training Compliance by Cost Centre Report September 2023

	Data source	ESR					Data snapshot	31/08/2023								
	Staff count of the number of training courses completed															
Cost Centre	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Grand Total	% with 100% Compliand
130 H315 JIGSO									1	1		1	1	1	5	10	50.00%
130 H318 Midwifery Flying Start NPT													1		2	3	66.67%
130 H408 SN Ward 20/Postnatal Ward				3	1	1		2	1	1	4	3	7	4	10	37	27.03%
130 H425 SN Obs & Gynae Medical Specialty	1			2	2	1	4	1	5	3	3	2	2	9	24	59	40.68%
130 H431 NPTH Birth Centre											3		2	4	17	26	65.38%
130 H433 SN Ante-Natal Clinic							1			2	1		1		11	16	68.75%
130 H435 SN Bay Birth Centre													1		5	6	83.33%
130 H437 West Community Midwives - South Team				1				1	1		2	1	3	8	13	30	43.33%
130 H443 SN Ward 19 / Antenatal Ward			1		1						2	1		4	15	24	62.50%
130 H444 SN Maternity	2		1			2		2	2	3	7	6	12	15	50	102	49.02%
Grand Total	6	5	6	9	8	9	10	10	12	15	33	23	63	100	433	742	

We received further evidence confirming low compliance with mandatory Gap and Grow training within the midwifery team. The information showed that 67% of midwives had completed Gap and Grow training in the last 12 months. No evidence was received from medical team.

This meant that HIW were not assured that **all staff** that engaged in the delivery of Obstetric care had received the relevant up to date training and skills to provide safe care and treatment to all women and babies in their care.

This poses a potential risk to the safety and wellbeing of women and babies.

2. The health board is required to provide HIW with details of the action taken: • **to improve compliance with all mandatory training**	Safe	**Health Board Core Mandatory Training:** Phased targeted improvement plan – minimum of 70% for all areas by 31.10.23 and 85% by 30.11.23. This includes ongoing training via Mandatory & Statutory (M&S) study days as well as prioritised rostering of staff who need support to achieve compliance which will be balanced by maintaining safe staffing levels. **Gap Grow Mandatory Training:** M&S study day on the 14.9.23 amended to include allocated time to undertake Gap Grow (2 hours allocated). This will be an ongoing change. Forward plan to roster dedicated time for Midwives to complete Gap Grow eLearning module with an aim to be 95% compliant by 30.11.23. Medical staff Gap Grow compliance is 88%. Clinical Lead is leading compliance improvement with aim to be 100% compliant of available staff by 30.11.23 (*12 obstetricians outstanding*). This will be discussed further at Audit Meeting on 18.10.23	Practice Development Midwives Deputy Head of Midwifery Head of Midwifery Clinical Lead	85% compliance by 30.11.23 Commenced 14.09.23 Target Compliance 95% by 30.11.23 30.11.23

• **to promote patient safety in the interim until compliance has improved** • **to improve the system in place to capture, monitor and improve training compliance for all staff in the department. To enable leaders to view training compliance in real time.**		and presentation shared to improve compliance. **Gap Grow and Health Board Core Mandatory Training:** These will be reported to the Maternity Training & Education (T&E) Forum and exception reported to the Maternity Quality & Safety (Q&S) Group. All Datix incidents will be reviewed, to ensure training is not a causal factor. **Core Mandatory Training:** Monitoring training compliance will be improved: All midwifery leads and the Assistant Divisional Manager who oversees medical staff now have access to ESR reports outlining training compliance. Training will be provided to area leads over next two weeks to enable them to use the system to access to compliance in real time. **Gap-Grow Training:** Prioritise Gap Grow training for Community midwives.	Clinical Lead and Head of Midwifery Assistant Divisional Manager and Head of Midwifery Head of Midwifery Community Matron	T&E Forum 04.10.23 Q&S Group 09.10.23 with ongoing monitoring Completed 02.10.23 20.10.23 31.10.23

		Perinatal Institute provide monthly reports to PDM's on SBUHB training compliance. Professional development midwives update HOM weekly on gap grow compliance following receipt of certificates. PDM continue to send out weekly reminders, with link information on how to access. Staff not compliant are also escalated to area leads to follow up with individual staff.		

Findings

Resuscitaire checking

HIW noted check logs of maternity unit resuscitaires were stored in a team room away from the individual resuscitaires. Given the mobile nature of the resuscitaires, HIW is not assured that the system for checks on resuscitaires offers sufficient assurance that they have all been checked to identify faults prior to use in an emergency and re-checked following each use.

Defibrillator checking

HIW checked a defibrillator on the resuscitation trolley in the unit (one of three defibrillators). We noted there was no evidence of daily checks recorded to identify faults prior to use in an emergency and re-checked following each use.

Therefore, HIW is not assured regular checks are being conducted in accordance with the health board's policy/requirements to ensure the required equipment is available and suitable to use in the event of a patient emergency.

This poses a potential risk to the safety and wellbeing of patients in the event of a patient emergency.

3. The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to ensure that all equipment is safe to use, functioning effectively and checked on a daily basis with evidence of checked located on / adjacent to individual pieces of equipment.		Intrapartum Lead & Ward Manager have implemented check list on every resuscitaire. The Band 7 co-ordinators will ensure compliance on a daily basis. Defibrillator added to daily checklist – Ward 20.	Intrapartum Lead/Ward Manager Obstetric Matron	Completed 11.09.23 with ongoing compliance monitoring Completed 18.09.23
Findings **Security** The inspection team considered the security of newborn babies in the maternity unit. [**Redacted**] This along with the midwifery staff shortages across the unit meant that HIW were not assured the unit was sufficiently protected to minimise the risk of baby abduction.				
4. The health board is required to provide HIW with details of further action it will take to ensure measures are in place to maintain the safety of babies across its maternity services to prevent baby abductions.		[Information supplied has been redacted]	Service Group Directors Obstetric Matron Deputy Head of Midwifery. Obstetric Matron &	14.09.23 Walkabout assessment completed 14.9.23 22.9.23 Drill feedback - complete

			Ward Manager 20 Obstetric Matron Obstetric Matron & Assistant Director of Capital Planning/Health & Safety Obstetric Matron & Assistant Director of Capital Planning/Health & Safety	30.11.23 policy update 30.11.23 31.12.23 13.10.2023 (Full completion of survey) 30.11 2023 (Complete implementation of enhanced egress controls)

Findings

Medical handover

We saw that medical handover is in place for intrapartum care and antenatal care, and these handovers occur separately with separate on call consultants. The intrapartum element of handover does not adequately capture those patients undergoing Induction of Labour, nor does it reflect the current status of patients on the antenatal ward. We were informed that the consultant looking after antenatal patients would discuss the patients on the antenatal ward with the labour ward consultant to plan safe care. There was no evidence that this takes place consistently and it is a risk that needs to be addressed urgently.

5. The health board is required to provide HIW with details of further action it will take to ensure that, medical handover between antenatal and intrapartum patient care is effective, routinely recorded and communicated, ensuring that all women across the unit are prioritised effectively and in a timely manner to maximise patient flow and minimise risk of deterioration.		A process has been implemented where the Antenatal handover sheet is signed by both the Antenatal Ward Consultant and Intrapartum on call Consultant to ensure record of handover process. Obstetric Consultant and Intrapartum Lead are undertaking an improvement in practice project focusing on the medical handover process. Commenced 11.09.23 and audit process to be confirmed for assurance. Results to be reported to the Maternity Quality and Safety Forum when completed.	Clinical Director Clinical Lead and Lead Midwife Intrapartum Care	Implemented in Consultant meeting on the 08.09.23 31.10.23 (Report to Forum)

Infection prevention and control

On 5 September 2023 in the low dependency unit, we observed the following:

- blood stains on a trolley
- blood soiled waste disposed of in a glass disposal bin
- delays with the changing of disposable patient curtains (one dated December 2022 and one date November 2022).

HIW is not assured effective processes were in place or being followed to prevent healthcare acquired infections.

6. The health board is required to provide HIW with details of the action taken to promote effective infection prevention and control and decontamination. • blood stains on a trolley • blood soiled waste disposed of in a glass disposal bin • delays with the changing of disposable patient curtains (one dated December 2022 and one date November 2022).	**Safe**	Blood stained trolley addressed immediately. Blood soiled waste in glass disposal bin addressed immediately. All orange bins are now situated in the clinical areas in line with the Health Board's Policy with regard to the disposal of clinical waste. Outdated curtains replaced. Agreement with Hotel Services on the 09.09.23 that the Housekeeping Team will monitor compliance. Further assurance will be gained by incorporating the check into the Matrons Monthly Assurance Audit Learning from HIW findings discussed with the whole MDT during safety brief and handovers in all clinical areas. DHOM, Matron, Ward Manager and Labour Ward Co-ordinators to complete weekly spot checks of the clinical areas until assurance provided. A similar process has been implemented for Ward 19 and Ward 20.	Labour Ward Co-ordinator Hotel Services Hotel Services Deputy Head of Midwifery Obstetric Matron	Completed 5.9.23 Completed 5.9.23 Completed 9.9.23 to be added to Matron's Audit by 29.9.23 Commenced W/C 11.9.23 Commenced W/C 18.9.23

Findings Medicine storage and checks - On 5th September we saw those two storage cupboards with keypad access storing fluids and medical equipment, were latched open with keypad access codes written on stickers on the doors. The cupboards were located on the main corridor to the unit with access available for any visitor, patient, or unauthorized member of staff. HIW is not assured fluids on the Maternity unit are being suitably stored to reduce the risk of unauthorised access. This poses a potential risk to the safety and wellbeing of patients and other individuals who may access, tamper with and / or ingest medication not meant for them.				
7. The health board is required to provide HIW with details of the action taken to safely secure fluids used on maternity unit to help prevent unauthorised access.	**Safe**	The stickers with the door codes were immediately removed. Door codes changed on the 11.9.23 Labour Ward Co-ordinators and Ward manager informed to ensure that cupboards remain locked. DHOM has been undertaking spot checks since HIW visit to ensure that the cupboards are locked and any non-compliance is reported to the Band 7 staff immediately.	Head of Midwifery Deputy Head of Midwifery Labour Ward Co-ordinators and Ward Manager Deputy Head of Midwifery	Completed 05.09.23 Completed 11.9.23 Completed 05.09.23 W/C 11.9.23 Implemented & ongoing
The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.				

Health Board Representative:

Name (print):	**Ceri Gimblett**
Role:	**Service Group Director, Neath Port Talbot & Singleton Service Group**
Date:	**06/10/2023**

Appendix C – Improvement plan

Service: **Maternity Unit, Singleton Hospital, Swansea Bay University Health Board**

Date of inspection: **5 – 7 September 2023**

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

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Quality of patient experience				
Staffing 1. Some comments provided by patients indicated that staffing problems had negatively impacted their experience.	The health board must reflect on the patient feedback in relation to staffing levels and implement improvements.	- Keep the Maternity Voices Partnership (MVP) forum updated with staff recruitment and plans for ongoing plans to attract staff into the service. - Develop a plan to further promote user feedback and ensure all feedback is shared and acted upon. - Explore the option to reintroduce volunteers back onto Ward 20 & Ward 19 as they can often provide very basic	- Head of Midwifery (HOM)/Consultant Midwife - Deputy Head of Midwifery (DHOM)/ Consultant Midwife - DHOM	- December 2023 - To commence February 2024 - January 2024

		support to women and staff. The outcome of the review to be feedback at the Head of Midwifery & Matrons meeting.		
Health promotion 2. We saw some health promotion information on the maternity unit and online. Online, there were links that were not working. There was limited availability of public health information in different languages.	The health board must ensure that pregnancy related public health information and links are available, and updated with the latest guidance and information for women and families. The health board must ensure that pregnancy related public health information is available in different languages.	- Broken links have been fixed - Review and update maternity website and consider wider opportunities for information sharing (Inc. public health information). - Explore options for auto-response to cover other language choices in the new the digital patient referral system. - The health board website has a functionality that translates text into other languages when selected by the user (and a user's browser settings can also automatically translate	- Head of Communications - Informatics Lead Midwife/Public Health Midwife/ Service Manager with the support of the support of the Health Board Digital Services. - Divisional service manager with the support of the Health Board Digital Services - Public Health Midwife	- Complete - March 2024 - February 2024 - January 2024

		pages into the language of their choosing). However, the service will review all information provided to patients in other languages.		
UNICEF Baby Friendly initiative 3. We reviewed the UNICEF Baby Friendly Initiative (BFI) information board in the day assessment area. Not all staff and healthcare workers that we spoke with were aware of the unit's Baby Friendly Initiative level of accreditation.	The health board must improve awareness of the UNICEF Baby Friendly Initiative, information and accreditation for women and staff.	- Work towards 95% compliance of staff attending two day BFI training. - Share level of HB accreditation on adverts and recruitment website. - Regularly share the HB BFI accreditation level at staff teams meetings, including HB breast feeding rates and adherence to guidance.	- Infant Feeding Lead Midwife/ Service Manager/DHOM - Infant Feeding Lead with support of Workforce lead - Infant Feeding Lead	- January 2025 - February 2024 - January 2024
Breastfeeding support 4. Women told us (in person and via the questionnaire) that there was not always support available to women in feeding their babies.	The health board should ensure the appropriate level of breastfeeding support, advice and guidance is provided to all women that would like to breastfeed whilst in the maternity unit.	- Provide feedback to staff regarding women's comments to ensure they are aware- to be included in safety briefs/hand over/ walk-around	- Ward Managers /Matron/HOM/DHOM	- November 2023

		- Embed the new MCA role within Maternity Services to support women with breast-feeding.	- Midwife Facilitator/Workforce Transformation Midwife	- September 2024
		- Recruit via research funding for a 12 month fixed term contract for HCSW (band2/B3) specifically trained to provide breast feeding support. Monitoring the impact of this post to use for future business case bids.	- Research Midwife & DHOM	- To be appointed July 2024
		- The service to review the option of reintroducing breast feeding peer supporters back into the postnatal ward with the local peer support group - feedback outcome of the review at HOM & Matrons meeting.	- DHOM and Infant Feeding Lead Midwife	- February 2024
		- With the support of the Clinical Supervisors for Midwives (CSFM) the Infant Feeding midwife will ensure all staff are	- Infant Feeding Lead Midwife & Clinical Supervisors for Midwives	- March 2024

		confident in providing breast feeding support to women – specific training to be provided to meet any identified needs - Regular bank and agency staff (Inc. HCSW) will be provided an update on SBUHB infant feeding training and BFI updates - Agree dedicated PALS time to undertake weekly face to face surveys on the unit to encourage feedback on patient experience.	- DHOM/ Infant Feeding Lead Midwife - Head of Quality Safety & Risk for Singleton & Neath Port Talbot Service Group/PALS	- March 2024 - To commence in December 2023
Environment 5. During the inspection the showers in antenatal ward were not all in use. We were told that the issue had been reported to estates and there had been delays in repair. This had negatively impacted patient experience.	The health board must implement a robust and effective process to ensure that estates faults and improvements are resolved in a timely manner and to a sufficient standard.	- Since the inspection, all showers have been repaired by the Estates team and are in working order. - Share findings of report with Health Board Estates Team and implement quarterly Infection Prevention	- HOM with support of Estates Team - DHOM, with support from Infection Control Lead & Estates representative	- Complete - To share in December 2023 and quarterly surveys from

		Control surveys to include maternity/infection control leads and Estates in all clinical areas, to ensure faults are identified and rectified promptly where it is possible to so. - The service will escalate IPC reports of unresolved issues via the Service Group Infection Control meeting. Risks associated with unresolved environmental matters will be recorded within the service risk register and escalated through service group and corporately in accordance with the health board risk appetite.	- HOM, Divisional Manager and Service Group Lead	January 2024 - March 2024
6. The location and access to the bereavement room was through labour ward, this impacted the privacy	The health board should review the current location for the Bereavement room with a view to moving the service to an area	- The maternity service will review alternative location of labour ward bereavement room –	- Bereavement midwife, Clinical Team, with support from representative	- January 2024

and dignity of women and families that may need to use this room.	away from the ~~middle of~~ labour ward / ensuring that patient access is not through labour ward.	ensuring the clinical safety of the woman is also maintained and provide feedback to the Service Group Directors.	from MVP and Estates lead	
		- To seek out other opportunities to maximise the privacy of the room.	- Bereavement midwife, Clinical Team, with support from representative from MVP and Estates lead	- April 2024
		- The Health Board will Benchmark facilities with other health boards	- Bereavement midwife, Clinical Team, with support from the MVP	- March 2024
		- Seek the support of a woman or family to share their experience in a story which may help to assist staff to support parents during this sad time.	- Bereavement midwife	- March 2024
		- Update the risk register to reflect the mitigations used due to the lack of dedicated bereavement area.	- Divisional manager & HOM	- January 2024

7. **Bay Birthing Unit** had three small birthing rooms that were small and space was limited to enable women the opportunity to mobilise. 8. There was one resuscitaire available for all 3 rooms and the unit was located away from main delivery.	The health board should review BBU to ensure that available space is maximised to enable women in labour to move around.	- Review the current layout of rooms in the BBU - Set up a project group to review the overall layout of the maternity unit on Singleton site (including the suitability of the 2nd Maternity Theatre – see Recommendation 23) to improve the environment of care and facilities	- DHOM & Matron - Consultant Midwife, HOM, Clinical Lead for O&G & Divisional Manager	- December 2023 - To commence September 2024
	The health board should risk assess the equipment available in the BBU to ensure sufficient emergency equipment (including hoists and resuscitation equipment) is available for women and babies in the event of an emergency.	- Benchmark against other units and review the standards - The Maternity service will risk assess the availability of the one resuscitaire in the BBU and monitor for any incident where more than one baby required resuscitation at any time, escalating the incident and reassessing the risk. In addition to the above, all the normal birthing rooms have	- Consultant Midwife - DHOM & Bay birthing Unit Lead midwife	- July 2024 - December 2023

		access to standard baby resuscitation equipment – as in homebirths and Free Standing Birth Centre – this will be maintained and checked regularly.		
Patient choice 9. On review of patient records, we saw that discussions around labour birth pain relief and feeding choices were not well documented. We noted suggested birth plans were not routinely completed in booking records. These should make reference to patients informed choices for labour and birth.	The health board must ensure that birth plans / women's choices for labour and birth are routinely recorded in patient notes.	- Evidence of Birth Plans being discussed with women and documented in their maternity records to be in monitored via monthly notes audit. These discussions should include birthing options, pain relief and feeding choices. - Feedback relating to the lack of documented birth plans to be shared with community midwives and the wider obstetric team.	- DHOM/Infant Feeding Lead Midwife - HOM & Obstetric Lead/ Maternity Matron	- To commence January 2024 - December 2023
Timely care 10. Some women on postnatal ward told us that they pain relief was not	The health board should ensure that appropriate pain relief is given in a timely manner.	- Fully implement self-administration of medicines across the service.	- DHOM, Matron with the support of the Pharmacy Lead for Maternity	- February 2024

always given in a timely manner.		- The Lead Governance Midwife will direct staff that all missed or delayed administration of pain relief must be reported via Datix and managed in accordance PTR.	- Lead Governance Midwife	- November 2023
11. We saw that many women were waiting for induction of labour due to staff shortages. These women were unhappy about the delays.	The health board should review and improve patient flow and patient experience, especially for those women going through the induction of labour process. The health board must mitigate any risks associated with capacity shortages to ensure that safe and effective patient care is maintained.	- The service aims to re-open the NPT Birth Centre which will assist with patient flow in Singleton. - Undertake a unit flow project and identify opportunities to improve safe, timely transfer out to the community.	- Consultant Midwife and wider Maternity Management Team - DHOM & Quality Improvement Lead	- April 2024 - April 2024
Communication and language **Listening** 12. Over 1/3 of the women that answered our questionnaire told us of poor communication and not feeling listened to.	The health board need to reflect on the less favourable patient comments in relation to communication and listening and consider how the service can be improved	- The service will share this feedback with staff at the weekly communication meetings – followed up by sharing of the presentation (to ensure staff not present at meetings receive the same key information).	- HOM & Obstetric Lead	- December 2023

		- To include this and subsequent feedback at future staff training & induction sessions which will include a patient story.	- Practice Development Lead/ Medical training lead	- March 2024
		- Monitor monthly feedback at Maternity service Q&S Forum	- HOM	- January 2024
Welsh Language 13. We found a limited amount of Welsh language information available on the ward via posters or printed material.	The health board must improve the active offer of Welsh language care for maternity service users.	- Review posters/leaflets and other information provided to women and request any not currently in welsh are translated.	- DHOM	- February 2024
		- Email maternity staff to advise of the Health Board Welsh language training available.	- HOM	- December 2023
		- Monitor Welsh language mandatory training uptake as part of the commitment to improving on the Welsh Language Standards.	- Maternity Service Managers	- March 2024
Other languages 14. We reviewed patient records and none noted a	The health board must ensure that patients from non-English / Welsh speaking backgrounds	- Reminder to be sent out to all staff regarding the importance of asking	- DHOM	- December 2023

preferred language. This could make communication difficult.	communication needs are met. Language preference must be noted in patient records. All staff should be made aware of importance of translation and communication support and translation services available.	women their preferred language and ensuring this is documented. - Remind staff of translation services available to the health board - Explore the feasibility of implementing a new language translation app – Language line solutions and provide outcome of the review at the divisional business meeting. - Monitor via record keeping audits that language preferences are being discussed and documented. - Submit request for WPAS amendment to ensure that ethnicity and preferred language is mandatory	- HOM - Informatics Lead Midwife - Ward Managers & Clinical Supervisor of Midwives - HOM with support from the HB Information Lead	- December 2023 - April 2024 - To Commence January 2024 - December 2023
Signage 15. We found that the maternity unit were not	The health board must improve maternity unit signage at the hospital (including from the car	- Link in with estates and MVP representatives to identify and address	- DHOM, Divisional Manager Hospital operations	- January 2024 (external signage via

clearly signposted from the main car park, the main entrance of the hospital, or throughout the hospital buildings. This could make it difficult for people to locate the appropriate place to attend for care and may also cause a delay to their care.	park and main entrance) to ensure that the maternity unit it is easy to find for all patients and visitors to the hospital.	areas for improved signage. As a priority, the health board is going to loom for a sign to be placed on the side of the building as you approach via the main access route, so it will be visible for people attending by car and /or walking. The date for delivery is to be confirmed (anticipated January 2024). - Any further changes and timescales will be agreed following wider review of signage on site with the operational management team.	- DHOM, Divisional Manager Hospital operations	main access route) - January 2024 (commissioning of further signage changes)
Rights and Equality 16. Up to date training compliance figures were not available for the mandatory diversity and equality training.	The health board must ensure that equality and diversity training is delivered and attendance monitored	- Ensure Mandatory diversity and equality training is attended and compliance is shared with the teams on a monthly basis via the Training and education forum.	- Matrons, Divisional Manager	- March 2024

17. We noted little evidence related to engagement with women and families from minority groups and diverse backgrounds, especially in relation to their feedback on care. (Through the Maternity Voices Partnership). There was limited information available for women from diverse backgrounds related to maternity care	The health board must improve engagement with women from diverse backgrounds and those with protected characteristics to gauge their feedback on maternity services to ensure that service provision is appropriate to their needs.	- Continue with the work Swansea Bay's MVP have commenced to increase representation of women from minority and diverse groups. Report on progress at the Maternity Voices forum. - The Health Board will explore opportunities to seek the views of women from minority groups via face-to-face discussions - Ensure the Swansea Bay University Health Board website is developed to support easy access to pregnancy information in other languages- (similar to the pregnancy 111 website)	- HOM & with support from MVP Lead - HOM - Consultant Midwife MVP lead with support from HB Communication team representative	- June 2024 - March 2024 - June 2024
Delivery of safe and effective care				
Risk management 18. Risks related to maternity care on the health	HIW need assurance that all maternity risks are reviewed regularly, that actions are	- Maternity services will re-review the health board risks to ensure	- HOM & Womens Health Divisional Manager	- December 2023

board risk register were past their target dates and had been added to the risk register over two years ago.	updated and escalated accordingly to ensure they are progressed and completed in a timely manner.	that the risks are up-to-date. - Link regularly with the corporate risk lead and ensure that we escalate updates regularly.	- HOM & Divisional Manager & with support from Assistant Head of Risk & Assurance	- January 2024
Staffing (also detailed in Appendix B) 19. Sustained period of staffing shortages. Rotas seen and feedback obtained to indicate that staffing levels for midwives regularly fell far below expected and safe levels. Most staff that answered our questionnaire stated that they were unable to meet all conflicting demands on their time at work.	The health board must consider the feedback from the staff questionnaire and consider how improvements can be made to better support staff. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	- Weekly Friday meetings will continue to be added to the diary giving staff an opportunity to keep up to date with senior managers. The weekly status presentation discussed during the meetings will be emailed to all staff. Any actions from the meetings to be logged and feedback given at future meetings. - We will use social media as a two way communication channel between staff and senior leaders. - Ensure all staff groups including cross-cutting	- HOM & Womens Health Divisional Manager - DHOM - HOM & Womens Health Divisional	- November 2023 - February 2024 - November 2023

		staff groups are included in weekly staffing updates and invites. - Continue with progress already made with the recruitment campaign in Swansea Bay and provide a progress update to the Divisional Business Meeting.	Manager - Workforce Lead, HOM & Womens Health Divisional Manager	- January 2024
Ultrasound capacity 20. We reviewed evidence and risk register that stated that there was not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP).	The health board must provide details of plans to mitigate the risks of not following national guidance regarding antenatal scanning for fetal growth as well as plans to increase capacity for scanning.	- Review the evaluation of the current midwifery scanning provision. - Identify the current gaps in provision and liaise with radiology services to develop a business case to achieve full compliance. - Until compliance is achieved, review the criteria for scanning to ensure capacity is targeted at the highest risk women and continue to report any adverse impact of non-compliance.	- DHOM & Womens Health Divisional Manager - HOM & Womens Health Divisional Manager with the support of the Radiology Services Manager. - HOM/Clinical Lead for Obstetrics/ Radiology Services Manager	- March 2024 - June 2024 - January 2024

Escalation 21. We reviewed an escalation process document which was not dated and no review date was in place. Some key clinical staff that we spoke to throughout the inspection were not able to define the escalation process or confirm minimum safe staffing levels for the unit.	The health board must ensure that comprehensive and effective staffing escalation procedures are followed and communicated to all clinical staff. This must include clear guidance of the process to follow when unsafe staffing levels are identified.	- Finalise the escalation policy, which is currently being updated and share with staff. - Recirculate the current Maternity Services Escalation Policy, highlighting the actions and escalation process required ensure continued provision of safe services. - Continue with daily safety huddles to look at staffing and acuity and escalation meetings to highlight concerns. - Following the final outcome of the OCP process and approval of new the arrangements which is expected in December 2023, we will implement an escalation plan which will include the minimum staffing levels for the unit.	- HOM/Obstetric Clinical Lead/ Lead Governance Midwife - DHOM - HOM/DHOM, Womens Health Divisional Manager & Singleton & NPT Service Group Directors - HOM with support from Workforce lead	- February 2024 - November 2023 - November 2023 - January 2024

Antenatal Assessment Unit 22. We reviewed processes, documentation, staffing and patient access related to the AAU and highlighted some concerns. (See full details in report).	The health board must fully review the activity, staffing, location and processes related to the Antenatal Assessment Unit to ensure safe and effective care for all women that contact the service.	- Undertake a review of the AAU service and its current location in the unit. The review will include ensuring referral criteria/ timeliness of assessments/ previous incidents reported to identify themes and gain feedback from women. The terms of reference for this review will consider each of the areas highlighted by HIW.	- DHOM/Service Manager/ Matron	April 2024
	• The health board must review the processes related to the staffing of the antenatal assessment unit and ensure that sufficient number and skill mix of staff are in place. The health board must ensure that AAU staff levels are included in the unit acuity tool to minimise risks around staffing on this unit.	- Completion of the OCP process and implementation of proposed arrangements will ensure that an additional midwife is available on Ward 19 to also support AAU when required. - Include AAU staffing numbers in daily acuity reports.	- HOM with support from the Workforce Lead - Maternity Matron	- April 2024 - Completed

	• The health board should ensure that all women in AAU/ Labour ward overseen by labour ward co-ordinator to ensure that front door function/activity is monitored in conjunction with labour ward activity and a safe and effective pathway of care can be ensured for all patients regardless of how they entered the unit.	- Reinforce the requirement of AAU staff to escalate to the labour ward coordinator when activity is increasing. - Continue to admit women arriving by ambulance directly to the labour ward for assessment.	- Maternity Matron - Clinical Teams	- December 2023 - Completed
	• The health board must review with a view to improving the telephone system for women calling AAU for advice to ensure that an effective system is in place for women to speak to a member of staff should the line be busy.	- Ensure that two telephone numbers are available to all women during pregnancy. - Continue with future plans to implement a new telephone system with one number for the whole service which will direct patients to the correct phone line first time.	- Maternity & Community Matron - DHOM/Service Manager/ Matron	- November 2023 - October 2024
	• The health board must complete a comprehensive	- A review of the telephone assessment	- Clinical Supervisor of Midwives and	- April 2024

	review of the telephone assessment process, information recording and sharing to streamline the process and improve safe and effective communication.	process / information recording & sharing will be included in the terms of reference of the review indicated earlier.	Maternity Matron	
	• The health board must perform a full audit of calls versus women seen over a period, including delays to 30 minute target and ensure improvements are implemented.	- Quarterly audit of calls against individual records will be conducted.	- Clinical Supervisor of Midwives and Maternity Matron	- March 2024
	• The health board must define and implement a formal process regarding patients that DNA following advice from AAU / Triage to be seen. This needs to be implemented to ensure the safety of women and babies. Furthermore, data related to DNA needs collecting and auditing.	- Audit admission to assessment times to ensure current AAU guidance is being adhered to. - Plan implementation of new AAU pathways and documentation process (BSOTS- Birmingham Symptom Specific Obstetric Triage System) - Current guidance will be reviewed to ensure that a process is in place in	- Maternity Matron, Ward 19 Manager - DHOM/Obstetric Matron - DHOM/Obstetric Matron	- April 2024 - September 2024 - February 2024

		AAU to follow up women who DNA AAU appointments and that this is being complied with.		
Obstetric theatres 23. In the 2nd Obstetric theatre, we noted some concerns in relation to its size and IPC. We considered this theatre unfit for purpose.	The health board must review suitability of the second obstetric theatre and make improvements to ensure that effective IPC is possible, the layout enables effective emergency obstetric care and that women that need to access theatre based obstetric care receive care in a theatre that is safe and fit for purpose.	- Undertake an infection prevention control review of the second obstetric theatre and agree action to mitigate risks identified. - The suitability of the second obstetric theatre will be included as part as the project referred to in recommendation 7.	- Theatre lead/ IPC team/intrapartum lead/matron. - HOM, Clinical Lead, intrapartum Lead and Divisional manager.	- January 2024 - September 2024
24. In times of high acuity, it is possible that a second obstetric theatre team be called in from off site.	The health board must ensure that the processes related to any required second obstetric theatre team have been effectively risk assessed and mitigations implemented to ensure safe, effective and timely emergency obstetric theatre care.	- This is already on the risk register. Any incidents are reported and jointly reviewed with theatre management. - Discuss with Theatre division the options to safely staff a second	- Governance Lead with support of the Theatre Lead. - HOM, Clinical Lead, Intrapartum Lead, with support of the	- January 2024 - January 2024

		theatre.	Theatre Lead and Divisional Manager	
ITU transfers 25. Patients that need a transfer to ITU, Critical Care or other emergency departments will need to do so by ambulance to a different site.	The health board should review the processes and provisions for woman and babies should an ITU transfer for an obstetric patient be necessary.	- To date the need for ITU transfers is kept to a minimum due to the continued level of obstetric anaesthetic support and HDU care provided on the labour ward.	- Lead Governance Midwife/ Divisional Manager/ HOM	- December 2023
		- The location of ITU is already on the Health Board Risk Register reflecting cross site working.	- Obstetric Clinical Lead & Lead Midwife for Governance with the support of The Obstetric Anaesthetic and ITU Lead	- April 2024
		- The recorded risk will be reviewed with reference to the current incident data and clinical reviews and if any increase in transfers will be escalated to agree actions as necessary.	- Obstetric Clinical Lead & Lead Midwife for Governance with the support of The Obstetric Anaesthetic and ITU Lead	- December 2023
		- The Health Board will undertake a review of the current arrangements for	- Obstetric Clinical Lead & Lead Midwife for Governance with the support of The	- April 2024

		transferring a woman requiring ITU care and gain support from the wider specialist Heath Board Teams.	Obstetric Anaesthetic and ITU Lead	
Lifts 26. On inspection, one of the lifts to the 5th floor (deliver) was not working. There is a risk of delay to patient care if lifts malfunction.	The health board must ensure that risks of malfunctioning lifts in the maternity unit are mitigated to minimise the risk of delayed care and protect patient dignity.	- Continue to monitor via the risk register - Service Group will link with Estates to look at a more permanent solution to maintaining functional lifts. - To explore with Estates the option of having an override system for Labour Ward use in at least one lift.	- Divisional manager - Singleton Hospital Site Manager with support of the Estates Department - Singleton Hospital Site Manager with support of the Estates Department	- December 2023 - December 2023 - January 2024
Incidents 27. Around 1/3 of staff that answered our questionnaire told us that they are not given feedback about changes made in response to reported errors, near misses and incidents.	The health board must improve processes and communication around feedback from incidents to staff.	- Staff to be advised that incidents are reported within the Datix system. Following completion of the investigation feedback is provided to the reporters by email within the Datix system.	- Lead Governance Midwife	- November 2023
28. At the time of inspection	The health board should review	- Recommence the	- Lead Governance	- February 2024

there were around 300 open incidents on the reporting system. This represents a significant backlog.	the reporting, investigation and management of concerns and clinical incidents with a view to expediting the process and timely sharing of any lessons learned or recommended changes in practice.	monthly newsletter for updates and ask staff for feedback on its structure and content. - Agree a revised process for timelier incident management and identification of themes and develop an action plan for completion of the backlog. - Continue to update daily on escalation meetings all incidents reported in the previous 24 hours. - Continue with temporary senior support for the management of incidents and concerns.	Midwife - HOM & Lead Governance Midwife - HOM/DHOM & Service Group Head Of Quality & Risk - Head Of Quality Improvement Lead For Service Group	- December 2023 - Completed - Commenced November 2023
IPC Uniform and bare below elbow policy 29. During the inspection, breaches of the health board bare below the elbow and uniform standard were noted and fed back.	The health board must ensure that staff conform with health board IPC requirements for bare below elbow and uniform. The health board must implement a full IPC audit and ensure that the IPC audit process is structured, effective,	- Ward managers and senior staff to ensure adherence to the uniform policy and bare below the elbow policy. - Continue with local spot check IPC audit and reinforce the message that it is everybody's	- Ward managers & medical leads - Ward Managers & Maternity Matron	- November 2023 - December 2023

	tracked and monitored to drive improvement.	responsibility to challenge non-adherence to this policy. - Request additional planned audits with the HB IPC team to monitor standards.	- Maternity Matron with the support of the HB IPC team	- To commence January 2024
30. Inappropriate location for the storage of placentas in the team room.	The health board must review where placentas are stored and locate them in an appropriate area of the unit.	- Review and agree an alternative locations for placenta storage.	- Maternity Matron & IPC lead	- December 2023
Blood management 31. Blood testing for patients is centralised in another hospital. This can cause delays around clinical decision making and care.	The health board must audit delays in blood results for obstetric patients and mitigate risks of potential patient harm as a result of any delays.	- An audit of incidents relating to delay s in obtaining blood results for obstetric patient for the previous 6 months (May to November 2023) will be undertaken to identify the level of risk.	- All Staff / Lead Governance Midwife	- Commence February 2024
Management of medical devices and equipment 32. HIW did not review formal process documentation or asset register to ensure that processes were in place to	The health board must ensure appropriate asset register log in place with formal processes in place for servicing and repair.	- Wide scale review of asset register to be undertaken to include service, repair, cleaning and decontamination.	- DHOM & Intrapartum Lead Midwife	- March 2024

ensure that equipment effectively serviced and calibrated.				
33. HIW found out of some out of date medical equipment (needles). This was addressed and they were removed during the inspection.	The health board must provide assurance of a robust system in place to ensure that out of date equipment is safely removed from the clinical area.	- Share the findings with staff and reinforce the procedures for monthly checking and documentation of stock items for expiry dates.	- HOM & Maternity Matron	- November 2023
Patient records 34. Some inconsistencies and illegibility in some of the records that were reviewed.	The health board must ensure that regular documentation audits are conducted and learning takes place from the findings.	- Findings in relation to standards of record keeping highlighted in the HIW report will be communicated to staff, and expectations re-affirmed with notice of planned record keeping audit arrangements. - A sample spot check will be undertaken of a subset of items (legibility of signatures and capital letters) following the above reminder. - Commence the annual	- HOM - DHOM - All Midwives &	- December 2023 - February 2024 Report findings by

		peer review record keeping audits in April 2024 and request all staff complete the audits by June 2024 in order to provide assurance of the standards for record keeping and share findings and any identified improvement as soon as possible. - When reviewing records for reported incidents or teaching sessions any examples of poor record keeping by individuals will be escalated to the line manager.	Obstetric medical Staff - Governance Lead Midwife & Lead Obstetrician for Governance	July 2024 - December 2023
Quality of Management and Leadership				
Governance and leadership 35. Many positions in the leadership structure were occupied on an interim basis.	The health board must review the interim leadership positions in the department and develop an effective plan to secure a stable and effective leadership team.	- Continue with plans for substantive posts to be advertised	- Service Group Nurse Director and Women Health divisional Manager	- January 2024

36. It was difficult to establish clear lines of reporting and accountability, no organisational structure could be produced.	The health board must update and share an organisation chart with key people and roles identified.	- Once appointed into posts, a new organisational chart will be finalised and shared.	- Women Health Divisional Manager	- March 2024
37. Staff told us that leaders were not always visible and that communication between senior management and staff is ineffective.	The health board must consider and act on all themes and comments from our staff survey.	- In future staff meetings- establish from staff what further senior leaders can do to support them and the service. - Involve the Clinical Supervisors to further discuss the support staff would like from their senior leaders and share the themes from HIW staff survey with the senior maternity leaders	- HOM/DHOM - CSFM	- December 2023 - January 2024
Guidelines and policies 38. At the time of inspection, many obstetric guidelines were in need of updating.	The health board must develop a robust plan to ensure the timely update and sharing of all guidelines and policies.	- Development of a Guideline and Policy group that will look at a RAG rated policy document to keep track of outdated or soon to be outdated policies.	- Consultant MW, Intrapartum Lead and Clinical Lead	- February 2024

Workforce 39. Midwives working in Singleton are not routinely trained in cannulation. This is in contrast to midwifery students; they are trained in cannulation. There is a risk of deskilling.	The health board must review the midwifery training skills and competencies and ensure that options are in place for consolidation of training.	- Train the trainers have been implemented which will support the roll out of cannulation training for all midwives.	- Maternity Matron	- March 2024
40. Specialist midwife roles in place are not fully embedded into health board structures.	The health board must review the specialist roles and ensure that they are effectively embedded into team and health board structures.	- Role descriptors for the specialist roles will be shared to provide clear information on how these posts are embedded into the maternity and wider HB services and groups to support the maternity vision.	- DHOM	- March 2024
People engagement, feedback and learning 41. More than half of staff said that they did not receive regular updates on patient experience. Almost 40% of staff told us	The health board must ensure that patient feedback is routinely fed back to staff. The health board must ensure	- Corporate patient feedback team now provide a monthly report for Maternity Services and this will be shared with all staff. - CSFM and medical	- Lead Governance Midwife - CSFM	- December 2023 - December

that they did not feel secure in raising concerns about potentially unsafe clinical practice.	that systems and processes are in place and communicated whereby staff feel secure to raise concerns about unsafe clinical practice.	education leads to continue to promote the importance of reporting concerns. - Senior clinical managers to encourage concerns to be shared at each contact with staff members. - The guardian service will continue to be promoted via email and shared at staff meetings across the maternity service. - The HB will explore any opportunities to provide cultural training/support for the maternity services.	- HOM/DHOM/Obstetric medical Lead/ Service Group Nurse Director - HOM/Obstetric medical lead - Womens Health Divisional Manager/HOM and Organisational Development Lead.	2023 - December 2023 - December 2023 - March 2024
Information governance 42. We noted occasions where patient information was not securely stored of disposed of.	The health board must implement a robust plan to ensure that patient identifiable records and information are secure and confidential waste is disposed of securely.	- Maternity Services have requested support from the Corporate Information Governance team on implementing more robust storage of confidential patient identifiable information.	- DHOM	- December 2023 (for feedback)

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): Sharron Price

Job role: Nurse Director, Neath Port Talbot Singleton Service Group

Date: 07/12/2023