Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Maternity Unit, Singleton Hospital, Swansea Bay University Health Board

Inspection date: 5 - 7 September 2023

Publication date: 15 December 2023

This summary document provides an overview of the outcome of the inspection

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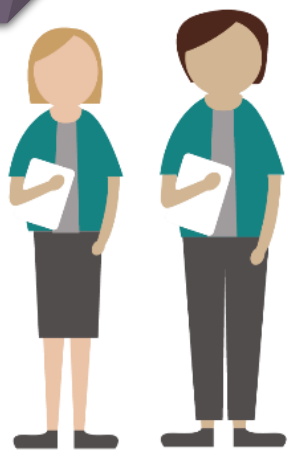
We found that staff worked hard to provide women and birthing people, and their families, with a positive experience despite the sustained pressures on the department. Staff were observed providing kind and respectful care, and people we spoke to were generally positive about the care they received from staff. Patient records we reviewed confirmed good daily care planning, which promoted patient safety and evidenced the care provided.

However, insufficient staffing was a key issue facing the health board. 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. In addition, many leadership positions are filled only on an interim basis.

Staff responses to the HIW questionnaire were generally negative, and less than half agreed that they would be happy with the standard of care provided by their hospital for themselves or for friends and family. Only a quarter said they would recommend their organisation as a place to work. Most staff we spoke with expressed significant concerns regarding the long-standing challenges around low levels of staffing. Many staff told us that this way of working had become normalised. Staff told us that processes were unclear around escalating risks related to peaks in clinical activity and acuity.

We highlighted significant concerns regarding many aspects of the delivery of safe and effective care. We were not assured that the processes and systems in place were sufficient to ensure that patients consistently received an acceptable standard of timely, safe and effective care. This included routine activities such as maintaining cleanliness, daily checking of essential maternity equipment and safely storing medicines and equipment. Concerns were also highlighted around the issues of staffing levels, and mandatory training.

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



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 Maternity Unit on 5 – 7 September 2023.

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.

This summary version of the report is designed for members of the public.

A full report, which 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 can be found on our website.

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.

Where the service could 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.

What we found this 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.

Patients provided us with the following comments:

“Midwives who cared for me were amazing, but the hospital was very understaffed, and the midwives didn't have a break.”

“Staff not available to do induction on few occasions despite being over the 12 days from due date.”

“All the staff we encountered were friendly, polite and supportive.”

“Breastfeeding support needs to be significantly better.”

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.

Where the service could improve

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 in accordance with the health board's policy/requirements to ensure all 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.

What we found this service did well

- Peer led ward audits

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.

Where the service could improve

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.

What we found this service did well

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

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 appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition, we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.