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 22 - 24 April 2024. The following hospital wards were reviewed during this inspection:

- Ward 20 - a postnatal (following delivery) ward
- Transitional care
- Ward 19 - an antenatal (before delivery) ward
- Antenatal Assessment Unit (AAU)
- Labour ward (including bereavement room and birthing pool rooms)
- Bay Birthing Unit, Midwifery led unit with a capacity of 3 beds with 2 birthing pools
- Low Dependency Unit
- High Dependency Unit
- Obstetric theatres (two).

Our team for the inspection comprised of two senior HIW healthcare inspectors, three clinical peer reviewers and a patient experience reviewer. The inspection was led by a HIW Senior Healthcare inspector.

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 13 questionnaires were completed by women and birthing people and 62 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Our previous inspection of the unit on 5-7 September 2023 highlighted the need for a number of improvements, particularly around staffing pressures and the number of interim posts in the leadership team. In addition to this inspection, we also requested an update on the Improvement Plan agreed following the September 2023 inspection.

We found the health board has made significant improvements to the service since our last inspection, but challenges remain. Staffing has improved since our last inspection, however, many staff we spoke to confirmed there were still issues in having sufficient skill mix to match the acuity of patients. Improvements to the leadership structure were evident with the appointment of a new permanent Director of Midwifery and Head of Midwifery, however, some leadership posts are still interim and are due to be filled over the coming months. Whilst the overall picture is improved, a number of improvements are still required, some of which remain from our previous inspection.

The updated Improvement Plan following the September 2023 inspection showed progress had been made against many of the improvements. For those where progress had not yet been made, future target dates for completed actions were detailed. It is expected that the health board will continue to work towards completing the actions from the September 2023 inspection as well as improvements that are identified in this inspection report.

Quality of Patient Experience

Overall summary:
Staff were observed providing kind and respectful care to patients and their families. We found that staff worked well as a team to provide women and birthing people with a positive experience that was individualised and focussed on their needs. All women and birthing people that we spoke to during the inspection were positive about their care and the staff.

This is what we recommend the service can improve:

- Discuss and document birth plans and choices
- Improve availability of information in different languages, including Welsh
- Improve the provision of bereavement facilities.

This is what the service did well:

- Staff trained in diversity and equality

- Promotion, provision and utilisation of translation services during care for women and families whose first language is not English or Welsh.

Delivery of Safe and Effective Care

Overall summary:
We saw, in general, arrangements were in place to provide women and birthing people with safe and effective care. We found there were robust processes in place for the management of clinical incidents, ensuring that information and learning was shared across the service. However, we raised some concerns around the Antenatal Assessment Unit.

Immediate assurances:
The following issues were raised during the inspection and resolved. Further details of the immediate improvements and remedial actions are provided in **Appendix A**:

- Harmful cleaning fluids were not always stored appropriately and safely
- Daily checklists for the resuscitation trolleys were taking place however the forms used were missing some essential equipment checks
- Fridge temperature monitoring for the patient fridge was not evidenced via a checklist
- Disposal of a paper telephone assessment contact form for Antenatal Assessment Unit, meant that an appropriate audit trail was not always available.

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

- Antenatal Assessment Unit staffing and processes.

This is what we recommend the service can improve:
- System and process to ensure staff have access to appropriate medical supplies and equipment
- Review and improve escalation policy and guidance with specific reference to staffing
- Continue efforts to address historical backlog of low level incidents logged on the DATIX system
- Formalise Standard Operating Procedures around the use of the second obstetric theatre

- Continue to build on progress around increasing capacity for fetal growth in the third trimester.

This is what the service did well:

- Infant feeding support
- Use of innovative methods to improve efficiency around incident review (Datix stickers and use of QR codes for sharing information)
- Safeguarding processes and procedures.

Quality of Management and Leadership

Overall summary:
A relatively new management structure was in place and clear lines of reporting and accountability were described.

This is what we recommend the service can improve:

- Introduce mechanisms for monitoring staff satisfaction, including feedback for leaders
- Monitor and improve levels and skill mix of staff to meet demand and clinical need
- Improve compliance with annual appraisal (PADR).

This is what the service did well:

- Improvement in the leadership structure and visibility.

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. Due to low numbers of HIW patient questionnaires completed, we reviewed further patient experience feedback provided by Swansea Bay University Health Board. We also spoke with many women and families during our inspection.

We reviewed the health board Maternity Service Group Patient Experience Report March 2024 feedback from women and families, whereby 154 responses were returned with an overall satisfaction score of 94% on March 2024, up from 90% in January and February 2024.

Comments included:

> *"Every staff member I came into contact with was outstanding. The care I received was excellent and I am very grateful" (Maternity Service Group Patient Experience Report 2024)*

> *"I would just like to say how amazing the staff on Labour ward are/were they made my whole labour less traumatic despite the emergency c-section. However, the same cannot be said for Ward 20. As a first time mother I wasn't supported or listened to by a few midwives and nursery nurse, although some midwives, nursery nurses and HCA's were great." (HIW patient feedback survey, comment from recent patient)*

> *"There was too many agency staff for a parent to become comfortable to ask questions, especially when the agency staff cannot answer them because they are not familiar with the hospital." (HIW patient feedback survey, comment from recent patient)*

> *"Organised, Professional, Profound level or care and comfort" (Maternity Service Group Patient Experience Report 2024)*

The health board needs to reflect on the patient feedback in relation to patient experience to track, monitor and implement improvements.

Person-centred

Health promotion

We saw 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. QR codes were displayed throughout the unit with working links to pregnancy and birth information for women and families. The use of QR code links ensured that information provided included current and up to date advice and guidance.

We reviewed appropriate online information for women and birthing people from Swansea Bay University Health Board, this included pregnancy and health promotion information. The online information was available in a range of different languages. There was limited information displayed that was available in languages other than English. We recommend that further efforts are made to 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. All women that we spoke to said that they were asked about their smoking habits and were offered support to stop at every appointment.

Dignified and respectful care

All women, birthing people and families that we spoke to during the inspection were complimentary of the care provided and told us staff treated them with dignity and respect. Most staff told us through the staff questionnaire they thought patient privacy and dignity was maintained (57/62). The inspection team heard staff being polite and helpful towards all women and birthing people and their families. We saw that shared bays were in use throughout the unit. These shared bays can compromise confidentiality, however examples of this were not witnessed during inspection.

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 was located at the entrance to the labour ward with patient access through the labour ward. This room appeared clinical and was lacking homely furnishings. The room had not changed since our previous inspection. This service would be better placed

away from other patient rooms to better support patient privacy and dignity at a very difficult time. An improvement in relation to the bereavement room was required in the previous HIW inspection. The health board must inform HIW of updates in relation to addressing the previous inspection requirement **"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."**

In addition, **the bereavement provision should be reviewed with a view to making the room more homely.**

Some midwives told inspectors that they do not always feel confident completing bereavement paperwork and others told the inspection team that they would like more support clinically around bereavement.

The health board should improve bereavement training provision for midwives.

Individualised care

All women and birthing people we spoke with during inspection told us that their choices around their care were respected.

On review of six patient records, we saw that discussions around birth plans were not documented. Women and birthing people may benefit from birth plan discussions with midwives during the antenatal period. Discussions around birth plans better prepare women and birthing people to ensure expectations are managed and they are empowered to make informed choices. On review of patient records, we also saw that discussions around labour birth pain relief and feeding choices were also not well documented.

The health board must ensure that discussions around birth plans / choices for labour and birth are held and routinely recorded in patient notes during the antenatal period.

Senior midwives confirmed that the Neath Port Talbot Birth Centre midwife led unit had been closed for some time. The option for women and birthing people to have their baby at home had also been removed during the staffing shortages. We were told that the removal of home birthing and the 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
At the time of inspection staffing levels for midwifery and medical staff were appropriate. All women and birthing people we spoke with told us that they received timely care. Conversely, staff members told us that providing timely care to women, birthing people and their families was sometimes difficult.

Few staff felt there are enough staff for them to do their job properly (10/62) and over half (36/62) felt they were unable to meet all of the conflicting demands on their time. Some staff comments include:

> *"We have outgrown our unit; we do not have the capacity to meet the needs of the women. The wards are more often than not full and inductions are pushed back as are elective caesareans..."*

Equitable

Communication and language
We saw that preferred language was documented in all records that we reviewed. We also noted that when translation services were used in the delivery of care, this was clearly documented. Posters were seen in clinical areas highlighting availability of interpreters through language line. Staff we spoke with were aware of and were accessing translation services to support women for whom English was an additional language.

We reviewed some evidence in relation to the September 2023 requirement to improve the active offer of Welsh for people using maternity services. We saw evidence of high levels of compliance for staff completing mandatory Welsh Language awareness training. However, not all health information displayed was available in English and Welsh, with some signs on some information boards indicating that "this information is available in English only."

The health board must further improve the displays to ensure that Welsh language is promoted as part of the active offer.

We were told that, as part of a recent initiative, preterm babies were given a preterm baby passport to share with clinicians once discharged. This was viewed as positive practice and aimed to improve communication, care and support for families with preterm babies.

Rights and Equality
Diversity and Equality training was mandatory for staff working in the unit and evidence of high levels of training compliance was noted.

Staff members shared examples of supporting people with protected characteristics under the Equality Act (2010) to communicate effectively and access services.

Senior leaders told us of appropriate initiatives that were in place and planned to improve diversity awareness and cultural competency. This included Equality and Inclusion champions within the team.

Our survey asked if staff had faced discrimination at work in the last 12 months based on protected characteristics and 4 of the 60 staff said that they had. In addition, 5 of the 60 told us that not all staff have fair and equal access to workplace opportunities. Further details were not shared.

The health board should reflect on the survey findings and make attempts to further explore and identify staff discrimination and ensure that appropriate action is taken.

Delivery of Safe and Effective Care

Safe

Risk management

There were established processes and audits in place to manage risk, health and safety and infection control. This enabled staff to provide safe and clinically effective care.

We reviewed evidence in relation to the frequency of antenatal scanning. Whilst we noted that this had increased since September 2023, it did not meet guidance 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.

We reviewed risk assessment information in relation to antenatal growth scanning that noted GAP Grow training as a mitigation. We reviewed training rates and confirmed that compliance with GAP Grow training at the time of inspection and confirmed that compliance was high at 90%. Senior leaders confirmed shared plans to continue to increase the frequency of Growth scanning in third trimester in line with national guidance and will continue to mitigate risks in the interim.

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

An updated escalation process policy dated 12 February 2024 was shared with the inspection team. This included actions for key team members, triggers and decision points. There was no clear process for the staff element of escalation detailed in this policy. Staff feedback on the escalation process was mixed. Some staff members we spoke to confirmed they were aware of the policy and most could describe a process to follow and / or where to find further information or guidance. Some staff were also able to describe the process for staff escalation, even though this was not evident within the policy. Other staff told us that they were aware of a process, however, the process was frequently not followed in practice. The Head of Midwifery confirmed that escalation procedures are being audited to ensure that the correct policy and process is followed.

This policy would benefit from further improvements in relation to how staff members are allocated in times of high acuity.

The health board must review and update the escalation policy to include a formal staffing escalation process and share details of how they will ensure that this process is followed.

We reviewed the Antenatal Assessment Unit (AAU) and noted that a number of challenges remained in this area.

We reviewed the updated AAU referral criteria as well as the Standard Operating Process (SOP) for staff to follow should a woman not attend following telephone triage. Staff confirmed that this SOP was followed.

Whilst we saw that some plans were in place to make the changes recommended in the previous HIW inspection report from September 2023, we noted that risks to the safety of women, birthing people and babies remained in AAU.

Staff provided examples of challenges and potential impacts on the delivery of safe care within the AAU current staffing structure and processes.

The issues of staffing, telephone triage, escalation and acuity monitoring in the Antenatal Assessment Unit was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Specific challenges related to the antenatal assessment unit are:

- We saw documentation, and spoke to staff, who confirmed continued challenges with the low levels of qualified midwifery staff in AAU that this service experienced delays related to assessment of women, sometimes to the extent that midwives felt unsafe. Midwives told us that they felt that the allocation of shifts on AAU was not done in a fair and consistent way and this added to challenges. NICE (2015) guidelines state that women presenting at AAU should receive their initial assessment within 30 minutes of presenting. Staff told us that staffing levels on AAU meant that this time target was regularly missed. The inspection team reviewed Datix incident reports that indicated that the 30 minute triage target continued to be missed.

- The AAU 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. There was no acuity tool in place for AAU at the time of inspection

- The AAU 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, especially when staffing levels were low

- Staff members told us that they did not feel supported in AAU and that there was little confidence that improvements will take place

- 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 was routinely thrown away, the sheets were 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 were concerned that there was a risk that communication may be missed and / or assessment delayed as a result. The standard practice of discarding of the telephone advise sheet was amended during the inspection (see below)

- No operational policy in place for AAU was available (although inclusion criteria was documented)

- The process for escalation was not clearly defined in processes and staff members that we spoke with at all levels, were not able to fully describe the escalation process for AAU.

The inspection lead informed the Head of Midwifery of the routine disposal of paper copies of initial telephone information taken from women who contact the AAU by telephone for advice. The process of disposing of this information was changed immediately and evidence was provided to confirm that all information was to be retained with immediate effect. Further details of the immediate improvements and remedial actions required are provided in Appendix A.

The health board must fully implement the recommendation in the previous HIW report following the inspection completed in September 2023. The health board must 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 AAU 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 invest in an acuity tool for AAU to that will assess the clinical needs of women and inform allocation of adequate workforce and staff mix for healthcare delivery. This should be overseen by the labour ward coordinator to ensure that AAU 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 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 develop and implement an appropriate operational policy is for AAU.**

During the inspection senior leaders confirmed the intention to move to a formal triage system in AAU. Staff told us that they were considering Birmingham Symptom-specific Obstetric Triage System which we concur with. This would have the goal of improving the safety of mothers, babies, and the management of the department.

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. However, the second obstetric theatre was small in layout and challenging to deliver all obstetric theatre based care. We reviewed a draft Standard Operating Procedure that related to the use of the second obstetric theatre on Labour ward, and whilst this document was not dated or finalised, it did detail the factors linked to the use of second obstetric theatre. It also detailed appropriate processes that should be followed to mitigate risks in the use of this theatre. Discussions with staff confirmed that the small theatre is used for surgical interventions that require fewer clinicians to allow for smaller space.

The health board must finalise, date and communicate the Standard Operating Procedure related to the use of the second obstetric theatre.

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

witnessed effective multidisciplinary working. We saw that women and their partners were supported and communicated with appropriately 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 was detailed in the Standard Operating Procedure). We were told that this is monitored through the Datix system.

During the first evening of inspection, we saw that cleaning fluids stored on AAU in Room 3 were not sufficiently secured. This was escalated to the midwife in charge and was addressed and secured immediately. No further incidents of unlocked cleaning cupboards were seen during the inspection. **Further details of the immediate improvements and remedial actions required are provided in Appendix A.**

We noted effective multidisciplinary team working in the review of incident reporting and significant events. Appropriate governance arrangements were in place to ensure that any incidents, of all levels of severity, were monitored, addressed and appropriate action taken in a timely manner to include learning disseminated appropriately. We viewed minutes and agendas from a range of meetings in relation to reporting and management of incidents and management of risk. These included weekly Datix meetings whereby all notes were reviewed. Clear governance processes in relation to the management of incidents were also seen. The Clinical risk team share a regular news bulletin with staff to share learning. We were told of the appropriate tools available to review incidents including tools to identify themes and promote learning. We noted that a QR codes was available for staff to access updated shared learning from incidents.

We reviewed the number of open cases of the DATIX system for Obstetrics and noted that the number of open cases was high but had reduced since the previous HIW inspection. We reviewed the breakdown of open cases during the inspection and leaders shared plans to further reduce the historic backlog of open incidents. Evidence of a comprehensive range of appropriate actions were in place to decrease this historic backlog. This included increasing implementing full incident days once a month with senior leaders to review and decrease the number of overdue incidents.

Leads confirmed that they had started to use Datix stickers to reduce delays in accessing notes needed for review. All midwives can add a Datix sticker to identify notes where a Datix has been recorded and to record the identification number. This has meant that delays in accessing notes for review have decreased, improving efficiency. **This was noted as innovative practice.**

We met with staff members leading this work, who confirmed that Nationally Reportable Incidents (NRIs) and Locally Reportable Incidents (LRIs) open on Datix were low in number at the time of inspection (less than 15). We reviewed information on the status of these incidents and confirmed that they were all being actively and appropriately tracked and monitored. We reviewed further evidence which confirmed learning from incidents had been shared and when appropriate, practice amended. Staff members confirmed that learning from incidents was actively and regularly shared.

Risk leaders confirmed processes and confirmed that all incidents graded moderate and above initiate the health board Duty of Candour process. All incidents graded as red / severe will be discussed with the patient safety team.

We were told all cases which are NRIs are reviewed in collaboration with the patient safety team. All MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reportable cases are reported to the NHS executive as 'must reports'.

All staff we spoke with told us that the organisation encouraged them to report errors, near misses or incidents. Almost all staff that answered the question on the survey confirmed that their organisation encouraged them to report errors, near misses or incidents.

Many staff said that the organisation treated staff who are involved in an error, near miss or incident fairly. When errors, near misses or incidents were reported, most staff confirmed that the organisation took action to ensure that they do not happen again. Most staff agreed that they were given feedback about changes made in response to reported errors, near misses and incidents.

The health board should continue their work to reduce the backlog of open Datix incidents in a timely manner and monitor progress.

Infection, prevention and control and decontamination (IPC)
We found that all areas of the unit that we inspected were clean and free of clutter. We reviewed audit reports indicating that regular IPC and cleanliness audits were taking place as part of the Matrons Monthly Quality Assurance Audits. We saw evidence that these were completed on a monthly basis. It was positive to see this improvement following recommendations within the previous HIW inspection report.

Appropriate documentation for cleaning processes were seen in relation to the cleaning of birth pools.

During the inspection we reviewed completed checklists for cleaning of rooms and equipment.

During the inspection we saw women on labour ward carrying bed pans full of urine through the ward from the toilet. We noted staff members intercepting the bed pans without wearing gloves/aprons.

The health board should review this process to ensure that IPC risks are minimised. An option is marking the bed pan with room number ask patient to leave in toilet to alert staff to review once completed.

Safeguarding of children and adults

The health board confirmed the policies and procedures were in place to promote the welfare of children and adults that may be at risk. All 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 that mandatory safeguarding training rates were included as part of the ESR mandatory training and compliance was 93% compliance for midwives at the time of inspection.

Following improvements recommended in a previous HIW inspection, we welcomed changes made to the labour ward exit, whereby the exit door is operated by a staff member to ensure that babies were safe. Staff described systems in place to ensure doors are automatically unlocked in the event of fire. We reviewed the baby abduction drill which included learning that had been disseminated to staff.

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.

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 evidence that checks were completed and recorded at least daily.

We reviewed checklists that confirmed resuscitaire checks took place twice daily and whenever a woman used a room. Checklists for drawer contents were present, however, at the time of inspection there was no checklist for the process of

checking suction, air flow, heater, or the gas bottles. There were no areas on the checklist form to highlight if there were any concerns or missing equipment. Staff told us that these checks did take place, however, the forms we viewed did not reflect this. This inspection lead shared this concern with the Head of Midwifery who addressed and resolved this immediately. Updated processes and checklists were implemented for all resuscitaires that included the checking of suction, air flow, heater and gas bottles. **This Immediate Assurance issue was sufficiently resolved during the inspection. Further details of the immediate improvements and remedial actions are provided in Appendix A.**

On the first night of the inspection, we noted in the walkaround there was no emergency trolley available on Transitional Care Unit, it was locked in a medicine cupboard a distance from the unit and was not easily accessible for staff to use in an emergency. On day two of the inspection, the trolley was moved to the corridor and was easily accessible. In addition, two new neonatal resus trolleys were obtained and were being stocked by Ward Manager, this resolution ensured that easy access to emergency trolley was available for women and babies for staff working in the transitional care area. **Further details of the immediate improvements and remedial actions are provided in Appendix A.**

Some midwifery staff we spoke with told us that they did not always have access to essential medical equipment to provide care to patients. This was confirmed by the staff survey, only half of staff said they have adequate materials, supplies and equipment to do their work. This posed a risk if prompt observations could not be conducted in a timely manner. One member of staff commented within the questionnaire:

> *"Equipment shortages, not enough CTG's to cope with demand & broken CTG's are not repaired timely. Also, very few handheld sonicaids."*

Some staff told us of delays to patient care and frustrations around time spent looking for handheld equipment to deliver clinical care.

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

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

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.

On the first evening of the inspection, we saw that lidocaine and sodium chloride flushes were readily available on an epidural trolley and other trolleys within the corridor on delivery suite. These were not within lidded containers.

The health board must review medicine storage on delivery unit to ensure that all storage for medicines complies with the medicine management policy.

During the subsequent days of inspection, no further medication left unattended was witnessed.

We noted improvements had been made relating to pain relief since our last inspection with the introduction of a ward schedule on Ward 20 and promotion of SAMS (self-administered medications). It was positive to see posters promoting this.

From HIW feedback forms as well as health board feedback, some comments were received in relation to delays for pain medication. It is possible that these were from before the changes took place on Ward 20.

The health board should monitor, review and act upon feedback in relation to delays related to pain medication.

Preventing pressure and tissue damage

We reviewed records whereby completed documentation was seen confirming completion of relevant and appropriate risk assessments related to pressure and tissue damage.

Effective

Effective care

We found suitable systems in place for capturing and sharing relevant information. We reviewed information related to the management and tracking of a wider range of audits and sharing of results and actions and these were in order. Audit information reviewed included monthly assurance records audit, matron audits (including IPC), environmental audit, Maternity early warning score (MEWS) audits.

Of note was the improvement in the engagement with estates to ensure that any estates issues are logged, addressed and resolved in a timely manner.

We reviewed appropriate monitoring tools including a Maternity Dashboard and Scorecard that was Red, Amber and Green rated, and updated monthly. We saw evidence that information and themes were appropriately shared.

Not all staff we spoke with were aware of dashboards and information available, although leaders confirmed that dashboard and scorecard information was available to all staff.

The health board should communicate developments in relation to the dashboard and scorecard monitoring of the unit to improve transparency and communication.

Most ward staff we spoke to indicated that the Senior Management Team (SMT) value their input and ideas and that staff are actively encouraged to contribute any ideas for change. Ward Managers confirmed that they have autonomy over how they make improvements on the wards and feel supported by SMT.

Nutrition and hydration
Women told us that there were food choices, and that water, hot drinks and toast was always available.

Completed fluid balance charts were seen in patient records that were reviewed.

There was an infant feeding midwife in post to support women and staff. We saw posters advertising daily breastfeeding group support at 10.00am in the Maternity unit. We spoke with staff and women who confirmed that this group supported them to breastfeed and provided an opportunity for peer support. This was viewed a positive practice in ensuring that women that would like to breast feed are supported in the early hours and days after birth.

We saw that some women bought food in and stored it in a patient fridge. We saw that daily **temperature checks on this patient food fridge were not in place, however, this issue was escalated and an effective daily process for the checking of temperatures was in place and evidenced by the end of the inspection. This issue was resolved during inspection. Further details of the immediate improvements and remedial actions are provided in Appendix A.**

Patient records
We reviewed six patient records. Overall, we found the standard of record keeping was adequate, with care plans well documented between multidisciplinary teams. We saw that the Modified Early Obstetric Warning Score (MEOWS) was completed consistently in records that we reviewed. Whilst we reviewed evidence of regular notes audits taking place, we did note some inconsistencies in some records. Some

signatures on entries were missing or difficult to read and one set of notes reviewed was not set out in chronological order and was missing some information.

The health board must ensure that:

- **Staff are reminded of the need to sign all relevant documents and ensure that the signature is legible**

- **Regular documentation audits are conducted and learning takes place from the findings.**

Quality of Management and Leadership

Staff feedback

Responses to our survey showed that two thirds of staff were satisfied with the quality of care and support they give to patients (41/62), only half agreeing that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (32/62), and fewer recommending their organisation as a place to work (25/61).

Many staff that we spoke with during the inspection however, confirmed recent improvements.

Staff comments included:

> *"Our staffing level has improved over the last 6 months and whilst skill mix is not always great - with time this will improve as the band 5's gain experience - however we remain exceptionally busy and are mostly unable to facilitate 2 midwives in triage (which was one of your recommendations on your last visit)."*

> *"Staff morale is low. We often miss breaks with no available staff to give support for breaks. We are regularly understaffed to a dangerous level… However, despite all of this I work with the most dedicated family centred midwives who strive to provide excellent care at the detriment of their own wellbeing."*

> *"…Not enough staff on the ward to enable good patient care & to give the support that women need at times of high acuity. Colleagues are great at supporting each other & teamworking."*

> *"Generally, a very positive place to work. Great teamwork from those on the floor despite being extremely stretched almost at all times. Unsafe working conditions due to poor staffing levels, rarely get breaks etc but despite this incredible staff morale, coordinators always trying their best to facilitate breaks where possible. Everyone striving to provide safe and woman centred care."*

Leadership

Governance and leadership

A management structure was in place and clear lines of reporting and accountability were described. After a period of instability in leadership it was pleasing to see a stable leadership structure was emerging.

We saw that there had been some changes within the senior management team since the last inspection in September 2023. The Head of Midwifery post is now filled on a permanent basis, although many midwifery leadership roles remained interim. Plans were shared to appoint to midwifery leadership roles on a permanent basis in the coming months. There is a new Clinical Director in post and the health board were awaiting a start date for the newly appointed Director of Midwifery.

Senior leaders told us that they had worked hard to increase staffing levels and make improvements throughout the unit.

During the inspection, managers were visible on all areas of the unit and many staff told us that they were approachable.

Feedback on immediate line managers was mostly positive. Most staff (50/62) told us that their immediate manager could be relied upon to help with a difficult task at work.

Feedback on the senior management team was mixed. Half told us that senior management were not visible and most (42/62) felt that communication between senior management and staff was not effective.

Comments from staff members included:

> *"Communication between managers and staff has improved."*
>
> *"Very limited contact with senior management, the contact we have feels very hierarchical and not supportive. Some of the senior team are not easily approachable and feel there is a lack of support..."*
>
> *"Senior management is difficult to get hold of and not visible in my work area."*
>
> *"Our ward manager works tirelessly with no support from CDS or top management, our ward is the last place to be looked after, patients are sent down relentlessly without care or consideration to staffing numbers or workload. All management care about is discharges and why people can't go home - implying Staff on the ward can't cope with the workload!!"*

Senior leaders confirmed that they have implemented some mechanisms for staff to feedback. These included fortnightly meetings held on site at Singleton attended by Executive Directors to which any member of staff can bring concerns. In addition to this there are confidential mechanisms such as the Guardian service available to staff. However, some staff told us that they did not always have confidence and assurance that actions will be taken on concerns that have been escalated. Examples provided of times information is dismissed or parked, staff do not have assurance actions will be taken on concerns escalated. Some examples of non-compassionate leadership were shared with the inspection team.

The health board should review and improve feedback mechanisms available for staff to feedback on leadership team.

Some staff highlighted the need to better implement an effective performance management system and processes for poor performing staff (midwives and doctors). This was recognised by some senior leaders who shared plans to improve mechanisms to support effective performance management.

The HIW staff survey indicated that 64% of those that answered would feel secure in raising concerns about unsafe clinical practice, although 92% would know how to report it. In response to the question "Are you confident that your organisation would address your concerns?" 37% of those that answered said yes.

The health board must improve mechanisms to support the effective performance management of staff.

Information was shared with us on the new Clinical guideline forum that has been established to act as gatekeeper between update / reproduction of guidelines and policies. Their role is to what need updating, review and agree updated guidelines before being uploaded to the Wisdom system. We noted that approximately 27% of guidelines needed addressing. We were informed that many of these may only need minor changes.

The health board must review, update and communicate the guidelines that are due for review / update.

Staff attend Band 7 meetings where representation from SMT is present. In addition, all staff stated that SMT attend the wards at morning and at the end of their day shifts to see if staff need any support or to see if there are any incidents or issues they need to be aware of. Most staff stated that the support and visibility of the SMT is positive.

Workforce

Following recommended improvements in the previous HIW inspection, it was positive to note that rotas showed midwifery staffing was now consistently at recommended levels in the unit as a whole. Many staff we spoke to (medical and midwifery) confirmed ongoing challenges with staffing, however, all recognised an improvement since September 2023. Extra shifts are available for staff to sign up to and a system was in place to ensure that staff who accept additional shifts are still able to take time to rest and recover.

Feedback from staff was mixed, and many told us that high acuity levels meant that staffing levels remained pressured. Some also raised concerns around the use of agency and bank staff. Whilst the evidence reviewed around staffing levels was improved, several negative comments were made specifically in relation to low staffing levels on Ward 20 and within AAU.

Comments included:

> *"The Midwives work extremely hard under extreme pressure at times and always strive to do their best. We are constantly working at high acuity and this adds to burnout and sickness. we are understaffed a lot of the time and do not have enough resources to pull staff in to help at times of extreme pressure. Staffing is always at the top of supervision discussions and this needs to change. Staff constantly work without breaks and work over their allocated time, this has become normal working on the good will of staff."*
>
> *"Staffing is a major issue in the unit. There is often time where escalation for further staff being needed on the wards and coordinator being unable to accommodate this."*
>
> *"The basic needs and care is not being given to the patients because there are so many complex cases or lengthy discharge processes that there is not time to actually provide care."*

The health board must monitor and improve levels and skill mix of staff in all areas of the unit to ensure safe and effective care can be delivered, patient experience is positive and staff wellbeing is protected.

We reviewed The Transitional Care Unit, and evidence indicated that the staffing allocated to this unit did not meet British Association of Perinatal Medicine (BAPM) guidance. Staff members that we spoke with shared concerns for patient care in that that there was not the recommended number and skill mix of staff in place for the Transitional Care Unit (TCU).

"Our role has recently changed to look after transitional care babies, 34+ week old babies requiring more specific work that we weren't aware of until it was in place and happening - and going wrong!!"

The health board must review staffing levels in Transitional Care Unit in line with to ensure the right number and type staff are in place and suitably trained in place in line with BAPM guidance.

Skilled and enabled workforce

We reviewed Performance Appraisal and Development Review (PADR) rates for midwifery staff over the last year. These were low at around 40% compliance rate.

The health board must share plans to improve compliance with PADR to ensure an effectively skilled and enabled workforce, to support wellbeing and to ensure that performance issues can be addressed and resolved in a timely manner.

We reviewed processes for monitoring staff attendance and compliance with mandatory training. Practical Obstetric Multi-Professional Training (PROMPT) compliance at the time of inspection was at 100% for doctors and 93% for midwives. Fetal surveillance training compliance was at 97% and Gap Grow training was at 88%. This indicated that the systems and processes in place for training staff in these mandatory areas are effective. This change represents a significant improvement in mandatory training compliance levels in September 2023.

Feedback from the staff survey in relation to training confirmed that most staff felt that they had appropriate training to undertake their role (40/60 agreed fully and 13/60 partially agreed).

We reviewed training data and systems for the monitoring of all mandatory training and whilst some systems appear complicated, the compliance rate for mandatory training was high and consistently above 75%.

The health board should consider improving the way in which mandatory training compliance is monitored and reported.

Culture

People engagement, feedback and learning

We saw that there was information in all areas of the unit detailing how women could feedback on their experiences. There was "You Said, We Did" information displayed detailing how concerns and comments from people have been used to

develop and improve the service. In addition, staff are emailed any positive comments or remarks received from women and birthing people via emails.

The Ward 20 manager also has a board for staff member of the month. We saw posters detailing Philosophy of care in different wards, displayed in public areas. Some staff feedback suggested that there were not sufficient opportunities for staff to feedback to senior leadership teams. Although senior leaders told us of an open door policy and an openness to feedback. It would be useful for leaders to formalise opportunities and mechanisms for staff members to provide feedback and improvements.

The health board should introduce mechanisms / processes to engage with staff feedback. To monitor, review and act on themes that emerge and to improve staff satisfaction.

We reviewed a range of health board information and survey data that indicated women and families feedback was obtained, reviewed, themes monitored and action plans implemented for improvements.

Many midwives and doctors that we spoke with told us that they felt that the culture on the wards was good morale has improved since staffing numbers have increased. An example of increasing applications for jobs at the health board was shared.

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. We saw evidence of patient information being stored securely. The information governance team were actively involved in ensuring that information is stored and destroyed appropriately. We noted that the confidential waste bin in a clinical area was not locked and had been highlighted in the previous HIW inspection. The Head of Midwifery informed us that the information governance team in the health board had been actively involved in risk management whilst lockable bins were sources.

There were packages that the unit used to ensure information and communications technology was used safely and effectively, ensuring that it enabled staff to work effectively.

Learning, improvement and research

We saw evidence of participation in a range of appropriate research programmes. One example shared was the DILAPAN research around induction of labour. We were told that midwives are trained and the success rate for this was high.

Further trials were shared around outpatient induction of labour, and initial findings were positive.

There were defined systems and processes in place to ensure that the maternity unit focussed on continuously improving its services. We reviewed evidence relating to clinical audit activity and disseminated learning.

We saw the service held regular meetings to improve services and strengthen governance arrangements.

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
Harmful cleaning fluids were not appropriately and safely stored in AAU (room 3) were not sufficiently secured.	This poses a potential risk to the safety and wellbeing of women and birthing people as well as other individuals who may access, tamper with and / or ingest substances considered hazardous to their health	This was escalated to the midwife in charge and was addressed and secured immediately.	This cupboard was appropriately secured immediately. No further incidents of unlocked cleaning cupboards were seen during the inspection.
Daily checklists for the resuscitation trolleys were taking place however the forms used were missing some essential equipment checks	The checks are essential to ensure that lifesaving equipment is in full working order for use in an emergency	This was escalated to the Head of Midwifery to ensure that resuscitation check lists included all checks	The check lists were immediately updated to include recommended checks and were in use from day 2 of the inspection

Fridge temperature monitoring for the patient fridge was not evidenced via a check list	The checks are essential to ensure that patient food stored in the patient fridge is stored at a safe temperature	This was escalated to the Head of Midwifery	A thermometer and check list process was communicated and implemented
Disposal of a telephone assessment contact form for patients contacting the Antenatal Assessment Unit.	Telephone assessment contact forms are an important communication log. They must be available to staff providing care to women that have contacted AAU to minimise the risk of miscommunication.	This was escalated to the Head of Midwifery	An immediate change to process was implemented and all telephone assessment contact forms are now retained in a folder.

Appendix B – Immediate improvement plan

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

Date of inspection: 22 – 24 April 2024

The table below includes any immediate non-compliance 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	Standard/ Regulation	Service action	Responsible officer	Timescale
Findings - Antenatal Assessment Unit (AAU) **We reviewed processes, documentation, staffing and patient access related to the AAU and highlighted concerns that represent a possible risk to patient safety.** **1) The process for telephone assessment was reviewed and it was confirmed that a non-clinical receptionist takes the initial call from a patient and completed a "Telephone Advice" sheet if the midwife is busy with another patient. The midwife calls the patient back to complete the telephone triage assessment.** **HIW reviewed the initial telephone call and triage process. We identified some of the information obtained from women being obtained by non-clinical staff. HIW are concerned that this process was is not robust and potentially placed women at risk.** **2) We reviewed AAU staffing levels that confirmed AAU was regularly staffed by one midwife and a receptionist. We reviewed evidence and incident logs that confirmed some patients did not receive their assessment within 30 minutes in line with national guidance.** **HIW spoke with staff members who confirmed they were unable to confirm escalation processes for AAU to keep patients safe.**				

As a result, HIW are not assured that consistently safe staffing levels and processes are in place in this area to ensure the delivery of safe and timely patient care.

1. **The health board must ensure that telephone information is taken by a clinically trained member of staff**	Standard - Safe	-The service will put a process in place for the midwife in AAU to take the clinical information from a woman who calls. The receptionist will answer the calls and either ask the midwife to speak directly with the caller or take the portable phone to the midwife.	Head of Midwifery	31 May 2024
		-A record sheet with the woman's demographics will be completed by the receptionist and the midwife will be responsible for completing and signing the clinical information section given which will be kept by the AAU team.	Head of Midwifery	31 May 2024
		-Monitoring of this action will be via the telephone recording system already in place and the information record sheets, and undertaken as part of monthly matrons' audits.	Ward 19 Sister	30 June 2024

2. The health board must increase staffing of the antenatal assessment unit to ensure sufficient numbers and skill mix of staff are in place		-The service plans to implement a new AAU pathway and documentation process (BSOTS- Birmingham Symptom Specific Obstetric Triage System) in September 2024 when the plan was to increase additional staffing.	Deputy Head of Midwifery	30 September 2024
		-AAU activity and acuity will be monitored as part of the daily staff huddle and handover. There are times where there are no women in AAU, so rather than allocate 2 midwives at all times to an area where there may be no activity, a midwife will be allocated to AAU at all times to take phone calls and they will escalate for the allocated second Midwife as required to ensure sufficient numbers and skill mix of staff are in place.	Labour Ward Coordinator	31 May 2024
3. The health board must update and communicate an effective staff		-A revised escalation flow chart specifically for AAU will be printed and	Deputy Head of Midwifery/Midwifery Matron	30 June 2024

escalation process for all staff members working within AAU.		available for staff to use – including labour ward coordinators.		

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: **Service Group Nurse Director, Neath Port Talbot Singleton Service Group**

Date: **03/05/2024**

Appendix C - Improvement plan

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

Date of inspection: 22 – 24 April 2024

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	**Some women and families shared experiences of poor care.**	**The health board should review the feedback and address.**	Safe	The service will work to increase the level of survey responses and ensure feedback themes are shared and acted upon.	Head of Midwifery	September 2024
				A patient feedback forum will be established to consider feedback, agree actions and monitor experience.	Lead midwife for Governance	October 2024
				The Health Board will consider the benefit and opportunities for the development of a	Clinical Director of Midwifery	April 2025

				specialist midwife for women's experience		
2.	**Display information was not always available in Welsh as well as English.** **Limited information seen displayed in other languages.**	The **health board should review and improve the provision of Welsh language display information in line with the active offer.** **The health board should consider additional information displays in other languages.**	Equitable	The service will implement further opportunities to ensure information is available in Welsh by undertaking a review across all the clinical areas with support of the Welsh Language leads in the Health Board. To date the Specialist Midwife for Health Promotion has added significant updates to information boards and the website – this will be maintained. The service will link with the corporate team to consider any future digital options that can display information in clinical areas in other languages. If there are no further digital opportunities the service will review options to	Deputy Head of Midwifery & Specialist Midwife for Health Promotion Head of Midwifery with support from the HB digital services	September 2024 November 2024

				establish non-digital means of provision and agree way ahead.		
3.	**The bereavement room that we visited was located on labour ward and was clinical and not homely.**	**The health board must review and improve bereavement facilities and support for women, families, and midwives. In addition, the bereavement provision should be reviewed with a view to making the room more homely.**	Effective	The service made initial improvements to the bereavement facilities and will continue to explore the future option of relocating the birthing room as described in the previous improvement plan. The service has developed a bereavement service review group terms of reference and plans to establish the group in order to promote ongoing improvements and monitoring of the Service Users of the services will be member of the group. The new plans to make the current room more homely have been costed and the service	Deputy Head of Midwifery & Bereavement Midwife	September 2024

	Some midwives told us that they were not always confident in completing bereavement paperwork.	**The health board should improve bereavement training provision for midwives.**		will gain support for the funding. The service will undertake a training needs analysis to establish the needs of clinical staff.	Bereavement Midwife	September 2024
4.	**On review of patient records, we saw those discussions around birth plans, labour pain relief and feeding choices were not routinely documented.**	**The health board must ensure that discussions around birth plans /choices for labour and birth are held and routinely recorded in patient notes during the antenatal period.**	Person centred	The findings of the report will be shared with the community teams emphasising the requirement to discuss birth plans/choices regarding feeding and pain relief with women and ensuring these discussions are documented in the maternity records. The community matron to monitor compliance and ensure the compliance and expectation of improvement in maintained.	Community midwifery Matron & Community Midwifery Teams Community midwifery Matron	July 2024 September 2024

5.	**On review of patient records, HIW found that in some records there were signatures missing or illegible.**	**The health board must ensure that:** • **Staff are reminded of the need to sign all relevant documents and ensure that the signature is legible** • **Regular documentation audits are conducted and learning takes place from the findings.**		Communication regarding the findings will be shared with the wider maternity teams. Documentation audit findings will be shared with the maternity team in July. Following the audit report the service will develop & implement actions to address findings. which will be monitored via regular ongoing audits to ensure improvements are made in maternity record keeping	Head of Midwifery and medical lead. Supervisor of Midwives and obstetric medical lead. Supervisor of Midwives and obstetric medical lead.	July 2024 July 2024 September 2024
6.	**Evidence reviewed indicated that the frequency of antenatal growth scanning in the third trimester had increased since September 2023, however, did not meet guidance from the UK Perinatal Institute**	**The health board must continue to mitigate the risks of not following national guidance regarding antenatal scanning for fetal growth as well as providing plans to increase capacity for scanning.**	Safe	In the previous improvement there was an action to review the current gaps in service provision by June 2024. The findings from the review will be developed into a business case to support full compliance.	Head of Midwifery, Obstetric clinical lead, service manager with support from radiology services.	September 2024

7.	**Escalation process does not detail clear processes for the allocation of staff.**	**The health board must review and update the escalation policy to include a formal staffing escalation process and share details of how they will ensure that this process is followed.**	Safe	The escalation policy for maternity services was updated in January 2024 – the service will undertake update training to the maternity terms on the policy. The maternity services – will explore what further actions can be taken to further formalise the policy.	Head and Deputy Head of midwifery Head of Midwifery	September 2024 August 2024
8.	**The Standard Operating Procedure related to the 2nd obstetric theatre was draft and not dated.**	**The health board must finalise, date and communicate the Standard Operating Procedure related to the use of the second obstetric theatre.**		The maternity and theatre services have completed and ratified the Standard operating procedure for the 2nd theatre – the Labour ward lead midwife and theatre lead will now communicate the requirements of the SOP to the wider teams.	Intrapartum lead midwife and theatre manager	August 2024
9.	**Some women on labour ward were seen carrying urine through the ward from the toilet. This represented an IPC risk.**	**The health board should review this process to ensure that IPC risks are minimised.**	Safe	The service will review how women provide urine samples for testing.	Intrapartum lead midwife	July 2024

10.	**We reviewed a high but decreasing backlog of open incidents in the Datix system.**	**The health board should continue their work to reduce the backlog of open Datix incidents in a timely manner and monitor progress.**	Efficient	The maternity services are continuing to manage the backlog of Datix incidents – with an aim to significantly reduce the backlog by November 2024. Regular update on progress will continue to be reported to the wider organisation.	Lead Midwife for Governance and obstetric clinical lead	In place and ongoing (action to reduce and monitoring)
11.	**Some staff shared examples of non-compassionate leadership.**	**The health board should review and improve feedback mechanisms for staff to feedback on leadership team.**	Effective	The workforce monitoring group will promote opportunities for staff feedback and ensure any feedback including that relating to the leadership team are monitored and acted upon. As part of promoting the opportunities for staff to give feedback staff will be asked how they would like to share their experiences.	Neath Port Talbot & Singleton service group workforce team with the support of the HB Organisational Development Team. As above	November 2024 September 2024

				Any themes identified and action taken to improve will be shared with the wider team to ensure	Maternity service management team with the support of the Neath Port Talbot & Singleton service group workforce team	December 2024
12.	**Half of staff surveyed told us that they did not always have access to essential medical equipment to provide timely care to patients.**	**The health board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment.**	Safe	The service will undertake a baseline assessment of equipment in the clinical areas to establish what is required. Staff will also be asked to report what equipment they require. A log of the equipment requirements for each of the clinical areas will be agreed at the Senior team forum and circulated to the areas. Any shortage of equipment against the log on any shift must be	Ward / unit sisters Midwifery Matron All clinical staff	August 2024 September 2024 September 2024

				reported to the manager via a Datix incident report for the senior team to investigate and resolve.		
13.	**Some medication on delivery unit (on the first evening of inspection) was seen on epidural trolley and not in a lidded container.**	**The health board must review medicine storage on delivery unit to ensure that all storage for medicines complies with the medicine management policy.**	Safe	Labour ward team will review the epidural trolley with the anaesthetic team to ensure any medication are safely stored.	Intrapartum lead midwife and anaesthetic lead.	July 2024
14.	**HIW patient feedback surveys and some health board feedback indicated that some women experienced a delay in receiving pain medication.**	**The health board should monitor, review and act upon feedback in relation to delays related to pain medication.**	Timely	The service re introduced self-administration of medicines (SAMs) in February 2024 – the uptake is being monitored by the ward sister. A review of the findings to date will be undertaken and any further action to improve uptake will be taken.	Midwifery Matron and ward managers for ward 19 & 20	July 2024
15.	**Four out of 60 staff respondents to the HIW staff survey felt that they had faced**	**The health board should reflect on the survey findings and make attempts to further explore and identify staff discrimination and ensure**	Equitable	The services with support from the corporate team will undertake a more in-depth survey to explore	Clinical Director of Midwifery Head of Workforce for NPT & singleton	November 2024

	discrimination at work in the last 12 months.	**that appropriate action is taken to prevent any further discrimination.**		this feedback further and develop a plan to address any specific issues identified.	Service group with support from the corporate workforce teams.	
16.	**Some staff and leaders shared concerns related to performance management.**	**The health board must improve mechanisms to support the effective performance management of staff.**	Effective	With support of the Health Board and further information from HIW, the maternity management team will explore this concern and where required will take action to improve in line with the HB values and polices.	Maternity management team with the support of the Neath Port Talbot Service group business team.	October 2024
17.	**Many staff that we spoke with were not fully aware of maternity dashboard and scorecard information for the unit.**	**The health board should communicate developments in relation to the dashboard and scorecard monitoring of the unit to improve transparency and communication.**	Effective	The senior midwifery team will ensure the wider maternity have access to the dashboard and receive the necessary training to access and navigate the dashboard. The senior team in conjunction with the wider maternity team will agree on a minimum dataset which can be	Deputy Head of Midwifery and Maternity Governance lead. Deputy Head of Midwifery with support of the governance lead	August 2024 September 2024

				shared on a monthly basis as part of the 'how are we doing' communication.		
18.	**Some areas of the maternity unit are not staffed in accordance with nationally recognised guidance or standards (AAU and TCU).**	**The health board must monitor and improve levels and skill mix of staff in all areas of the unit to ensure safe and effective care can be delivered, patient experience is positive and staff wellbeing is protected.**	Safe	Staffing levels for the AAU were being reviewed in response to the September 2023 inspection. Since the further inspection in April 2024 numbers have been increased to 2 per shift. The service will continue to monitor this and ensure low staffing incidents are escalated. TCU actions are set out in recommendation 19	Midwifery Matron	July 2024
19.	**Staffing levels and skill mix reviewed for Transitional Care Unit indicated that staffing levels were not in line with recommendations from British Association of Perinatal Medicine.**	**The health board must review staffing levels in Transitional Care Unit in line with to ensure the right number and type staff are in place and suitably trained in place in line with BAPM guidance.**	Safe	The service will review the occupancy of the Transitional care unit (TCU) and ensure the staffing levels meet the BAPM standard compliance. The service will undertake a training needs analysis for the	Midwifery Matron Educational leads for maternity with	October 2024 September 2024

				staff working in the TCU and ensure any training requirements are provided.	support from Neonatal services training lead.	
20.	**Low levels of annual appraisal compliance (40%).**	**The health board must share plans to improve compliance with PADR.**	Effective	The service will develop a plan to demonstrate how they will increase the uptake of annual appraisals.	Deputy Head of Midwifery & Matrons	September 2024
21.	**System for monitoring mandatory training appears time consuming and difficult to navigate.**	**The health board should consider improving the way in which mandatory training compliance is monitored and reported.**	Effective	The educational leads will work with the Service group and training system leads to develop a system to support easy and up to date access of training compliance.	Maternity Training team with the support of the Neath Port Talbot & Singleton Service Group and Corporate training lead.	October 2024
22.	**No evidence of formal processes in place to capture and monitor staff feedback.**	**The health board should introduce mechanisms / processes to engage with staff feedback. To monitor, review and act on themes that emerge and to improve staff satisfaction.**	Effective	The workforce monitoring group will consider and promote opportunities for staff feedback and ensure feedback is monitored and acted upon.	Head of Midwifery & Neath Port Talbot & Singleton service group workforce team with the support of the HB Organisational Development Team.	November 2024

23.	**Approximately 27% of guidelines on Wisdom were due for review and update.**	**The health board should share plans to ensure that guidelines are reviewed, updated and communicated in a timely manner.**		The maternity service through the policy review group will prioritise the guidelines for review and provide an update on progress through the Maternity Quality & Safety meeting.	Chair of the policy review group, Clinical lead for obstetrics	October 2024

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):

Job role:

Date: