Informal Ministerial Briefing

Official Sensitive

Healthcare Inspectorate Wales – Inspection Report of Singleton Maternity, Swansea Bay University Health Board

This briefing is to advise the Minister that Healthcare Inspectorate Wales (HIW) is due to publish an inspection report of Singleton Maternity, Swansea Bay University Health Board, which took place on 5-7 September 2023.

This informal briefing is provided in line with HIW's publication policy.

A copy of the embargoed report is included in **Document 1**, along with a copy of the public summary in **Document 2**.

Background

HIW undertook an unannounced inspection of Singleton Maternity on the evening of the 5th, and two full days on the 6th and 7th September 2023.

Summary of findings

We identified issues regarding many aspects of the delivery of safe and effective care within the unit. We found that there were issues with safe staffing levels not always being met and this was having an impact on the quality of patient care, and the wellbeing of staff.

We were not assured that the processes and systems in place were sufficient to ensure that patients were consistently receiving an acceptable standard of care. We found issues with low levels of mandatory training compliance and inadequate security measures to ensure babies were kept safe and secure. We also identified issues around arrangements for maintaining cleanliness, routine checking of essential lifesaving equipment, safe storage of medicines and safety issues relating to the hospital environment.

Whilst staff were observed providing kind and respectful care, and 60% of women and birthing people we spoke with were generally positive about the care they received, some women raised concerns over staff availability, delays, and sufficient support. For instance, some women reported a lack of breastfeeding support, long delays waiting for pain relief, and prolonged waits for the induction of labour procedure to start.

We also identified issues regarding:

- Maternity risks on the health board’s risk register had not been reviewed or updated regularly
- 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 staffing levels for the Antenatal Assessment Unit (AAU) not being included in the unit acuity tool, meaning that the service could be experiencing peaks in demand and complexity of cases without these challenges being effectively escalated.

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. We also noted good practice around the training delivered to staff by the team responsible for risk and incident reporting. However, there is significant backlog in managing and resolving incidents with around 300 open at the time of inspection. This meant that it is likely that learning was not undertaken in a timely and effective way to reduce the risk of reoccurrence.

We received very negative responses to our staff survey and this feedback reflected the impact of sustained periods of pressure and low staffing levels. Less than half of respondents agreed that they would be happy with the standard of care provided by the hospital for themselves or their loved ones. Midwifery staff also told us they were struggling to cope with their workloads and were concerned about their own health and wellbeing. In addition, most leadership roles within the department were temporary and there have been challenges maintaining a stable leadership team over the last two years.

In view of the significance and volume of negative responses to the staff survey, we have shared an anonymised version of these responses, alongside the patient survey, with the health board to inform its improvement work.

We identified a significant number of areas which had to be raised through our immediate assurance process, where we write to the service within two days of the inspection requiring a completed improvement plan within one week. The seven areas were:

- Midwifery staffing levels. We 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.
- Poor compliance with mandatory training across all topics
- The quality and effectiveness of medical handover between intrapartum and antenatal care
- Arrangements for resuscitation equipment checks
- Infection prevention and control issues
- Safe storage of medication
- Security of newborn babies in the unit.

We initially partially accepted the health board’s initial response to the immediate assurance process. Further detail around actions regarding staffing levels, mandatory training, and security was provided and we accepted the re-submitted response. A total of 38 general areas for improvement were further identified. These included issues around patient information, access to breastfeeding support, location of the bereavement room, pain relief being given in a timely manner, and engagement with people from diverse backgrounds. We also raised issues around escalation procedures, and infection prevention and control.

Whilst the health board provided a response to the recommendations, we needed further assurances on 15 areas as we were unhappy with some of the stated timescales, and level of detail of some responses. An improved response was submitted and accepted on 11 December 2023. The report at **Document 1** contains the accepted response to the recommendations.

Communication and media activity

We expect there to be significant media interest in our report. We intend to publish the inspection report and public summary to our website on 15 December 2023 at 9am and will reference via social media across our platforms throughout the day. We will be providing a copy of the report and public summary under embargo, along with a press release, to our media mailing list and key stakeholders on the 14 December. We will consider media interviews on request.

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11 December 2023