Hospital Inspection (Unannounced)

Singleton Hospital Maternity Services: Ward 18, Ward 19, Labour Ward and Midwifery Led Unit, 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 people in Wales are receiving good care.

Our values

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

Our priorities

Through our work we aim to:

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

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Singleton Hospital within Swansea Bay University Health Board on the 24, 25 and 26 June 2019. This inspection is part of HIW's national review of maternity services across Wales[1].

The following hospital wards were visited during this inspection:

- Ward 18 - a postnatal (following delivery) ward with a capacity of 21 beds and 1 cubicle designated as a bereavement room for women to receive care in the postnatal period
- Ward 19 - an antenatal (before delivery) ward with a capacity of 16 beds
- Antenatal Assessment Unit (AAU) with a capacity of 4 beds, located on ward 19
- Labour ward - (during delivery) with a capacity of 10 beds, two high dependency beds and three low dependency beds (currently under refurbishment)
- Midwifery led unit with a capacity of three beds together with two birthing pools.

Our team, for the inspection comprised of three HIW inspectors, three clinical peer reviewers (one consultant obstetrician and two midwives) and one lay reviewer. The inspection was led by a HIW inspection manager.

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

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

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

2. Summary of our inspection

Overall, we found evidence that the service provided respectful, dignified, safe and effective care to patients. However, we identified that improvements were required to further promote the safe and effective care of patients in accordance with national guidance and the Health and Care Standards.

This is what we found the service did well:

- Patients rated the care and treatment provided during their stay in hospital as excellent and positive feedback was seen on the initiatives being trialled
- There was a safe and robust process on each ward inspected for medicines management
- Documentation was of a very high standard
- Offering a Preferred Place of Work[2] to staff with five years' service or more, promoting experience and ownership
- Recent consultant expansion is working towards 24 hour consultant on-site labour ward cover.

This is what we recommend the service could improve:

- Signage at the hospital to ensure it is easy to read for all patients and visitors to the hospital, and correct floor announcements within the patient/visitor lifts

[2] Preferred place of work – introduced August 2017 allowing for midwives who had been in role for 5 years or more are given the option to request their preferred place (community/acute-antenatal/postnatal/intrapartum) to work within.

- Display and availability of information on the NHS complaints process
- Smoking by the entrance to the unit
- The birthing pool process and training to ensure patient and staff safety
- Review of the Working Time Directive[3] relating to the allocation of community midwives within the unit
- Audit management to ensure consistency and promote sharing and learning
- Approach for medical handover
- Visibility and presence of senior management team within the unit to improve staff morale.

[3] https://www.gov.uk/maximum-weekly-working-hours

3. What we found

Background of the service

Singleton Hospital is located within Swansea Bay University Health Board. The health board was created on 1 April 2019, after responsibility for providing healthcare services in the Bridgend County Borough Council area passed from Abertawe Bro Morgannwg University Health Board, to the new Cwm Taf Morgannwg University Health Board. The health board covers a population of approximately 390,000 in the Neath Port Talbot and Swansea areas of South West Wales.

The health board has three acute hospitals providing a range of services; these are Singleton and Morriston Hospitals in Swansea and Neath Port Talbot Hospital in Port Talbot. There are a number of smaller community hospitals and primary care resource centres providing clinical services outside of the three major hospitals.

Maternity services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provide care to women who chose to birth in the health board facilities, who reside outside the geographical boundary or who are transferred to Singleton Hospital. This is provided should their baby require care from the level of three neonatal intensive care units for the West of Wales region or beyond.

In 2018-19 a total of 5,574 births occurred within the former Abertawe Bro Morgannwg University Health Board. Of these figures, out-of-area births accounted for 535 births.

Women who birth within the health board have the choice of four birth settings. These include a homebirth, free-standing midwife unit (FMU) at Neath Port Talbot Hospital, an alongside midwife unit (AMU) and Obstetric Unit (OU) within Singleton Hospital. All midwife led intrapartum care settings have access to the Obstetric unit when complications arise in labour.

Quality of patient experience

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

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

We recommended that information on how patients, their families and carers can raise concerns about their care is readily available and clearly displayed.

Patients and families should also be made aware of the Community Health Council (CHC) for advocacy and support.

During the inspection, we distributed HIW questionnaires to patients, families and carers to obtain their views on the standard of care provided to patients. A total of eight questionnaires were completed. We also spoke on average, with eight patients each day during the inspection.

Patients who completed questionnaires rated the care and treatment provided during their stay in the maternity unit as excellent (scores were detailed as eight out of ten and above). Patients and their families who we spoke with also said they had a good experience in the whole of the unit. Patient comments included:

> *"All the staff have been very supportive, informative and allowed us to make informed decisions"*
>
> *"Midwife stayed beyond her working hours was amazing".*
>
> *"Staff go above and beyond, patient care is consistent and patients are very happy with the care that they receive".*
>
> *"We are confident in the midwives and medical staff that look after them us".*
>
> *"Midwives and medics give exceptional care".*

Staying healthy

The hospital was a designated no smoking zone. This also extended to the use of vapour/e-cigarettes. However, patients were seen to be smoking in the

entrance to the unit, which did not comply with Smoke-free Premises etc. (Wales) Regulations 2007[4]. We advised the health board to consider how they can ensure the area remains smoke free.

Dignified care

During the course of our inspection we saw many examples of staff being kind and compassionate to patients. We saw staff treating patients with respect, courtesy and politeness at all times. Most comments within the patient questionnaires were positive.

We also saw staff promoting privacy and dignity when helping patients with their personal care. We reviewed care documentation and did not find any areas of concern.

Half of the patients who completed the questionnaire confirmed that they were offered the option to communicate with staff in the language of their choice. Just over a third of patients said they couldn't remember.

Patients were asked in the questionnaires whether they agreed or disagreed with a number of statements about the maternity staff. All but one of the patients said that staff were always polite and listened, to them and to their friends and family. In addition, all of the patients said that staff called them by their preferred name and explained their birth options, any risks related to their pregnancy and the support they had been offered.

Antenatal care

Half of the patients who completed questionnaires told us they did not see the same midwife in the maternity unit as they did at their antenatal appointments. The majority of patients were six to twelve weeks pregnant when they had their booking appointment. All but one of the patients said they were offered a choice about where to have their baby, and said the midwife asked how they were feeling and coping emotionally in the antenatal period.

Labour care

[4] https://www.legislation.gov.uk/wsi/2007/787/contents/made

All of the patients who completed a questionnaire told us that a midwife stayed with them during labour. The patients also felt that they and their partners received enough support from staff to help them cope to work with the pain of labour. The patients also stated that the pain relief received during labour was adequate. The majority of patients who completed a questionnaire said when giving birth, they required the use of forceps/ventouse[5], to assist the delivery.

Postnatal care

Every patient who completed a questionnaire confirmed that a birth partner had been able to stay with them for as long as they wanted. All but one of the patients confirmed their postnatal stay had been more than 24 hours.

Patients said that midwives had discussed with them about the emotional changes they may experience after giving birth. Patients also told us that midwives gave support to help feed their baby by their chosen method and respected their decision.

Patient information

We found that directions to the maternity unit were not clearly displayed throughout the hospital. This could make it difficult for people to locate the appropriate place to attend for care. The lifts were used to access higher and lower floors. However, we found the signage to be confusing as it did not clearly display which ward/section was on which floor. This could pose problems for people finding the right ward.

Notice boards throughout the unit highlighted some items of health promotion, such as breastfeeding, Bump, Baby and Beyond[6] and smoking cessation, however, this was not consistent throughout the unit. There was also a lack of daily staffing details such as name and designation of staff, so that patients and their families/carers are aware of who is caring for them.

[5] https://www.nhs.uk/conditions/pregnancy-and-baby/ventouse-forceps-delivery/

[6] This book is written by parents, health professionals and child psychologists and has a wealth of useful information which will support parents all the way from the early stages of pregnancy, through to the early days with baby and into the toddler years.

Visiting times were displayed within the unit and staff advised that there would be flexibility in these timings if requested.

Staff we spoke with were aware of the translation services within the health board and how they were able to access these. Welsh speaking midwives were also identifiable by the Welsh speaker logo[7] on uniform.

Improvement needed

The health board must ensure that:

- Signage at the hospital is reviewed to ensure it is easy to read for all patients and visitors to the hospital
- Notice boards are reviewed to provide health promotion information such as post-natal mental health, UNICEF[8] baby friendly initiatives and support groups
- Information about staff is displayed for patients.

Communicating effectively

Overall, patients seemed to be positive about their interactions with staff during their time in the unit. Most patients who completed a questionnaire told us that they could always speak with staff when they needed to. The majority of patients also said, that they felt that they had been listened to by midwifery and medical staff during their stay. Most patients also told us that staff had always spoke with them about their birth choices.

We were told by staff on each ward, that midwifery and medical staff met separately at set times every day when shift changes took place. This was in order to communicate and discuss patients' needs, plans, relevant risks, any safety issues and to maintain continuity of care. We also saw that staff had

7 The Iaith Gwaith brand is an easy way of promoting Welsh services by identifying the Welsh speakers on your team. If someone is wearing a badge, or lanyard, this shows that they can have a conversation in Welsh.

8 https://www.unicef.org.uk/babyfriendly/

access to prepared patient handover sheets, which were updated daily, so that all staff were aware of key patient treatment, care plans and any significant issues.

Each ward had a patient safety at a glance board[9] which was used on a daily basis by multidisciplinary teams. These boards clearly communicated patient safety issues and daily care requirements or plans, as well as individual support required and discharge arrangements.

We saw that staff attempted to maintain patient privacy when communicating information. We noticed that it was usual practice for staff to close curtains around patient beds within the ward when providing personal care and support to protect their privacy and dignity. However, some patients we spoke with said they would prefer the curtains to remain open. Staff also acknowledged that closing curtains could possibly cause patients to feel isolated. The health board is advised to review these arrangements and consider the wishes of patients alongside arrangements to protect their privacy and dignity.

We were also advised by some staff that they would use 'Horizon[10]' to electronically communicate information to patients, which we noted as good practice. We were also able to access the internet page for the services and we were also advised that there is a Facebook social media page.

Timely care

We noted that the health board were currently in the process of recruiting into five current vacancies of whole time equivalent midwives. We were advised by the senior management team that these positions would hopefully be filled by September 2019. We were also assured that the risks around staff vacancies

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

10 Horizon is a free electronic application to provide information available on all aspects of midwifery care to women

were included within the unit risk register and were being managed appropriately to ensure safe and timely care.

We found that each ward ensured patients were regularly checked for personal, nutritional and comfort needs. This was confirmed within the selection of patient care records we reviewed and also by speaking with patients.

Call bells were seen to be easily accessible and were responded to within a timely manner when activated. Water, hot drinks and a full selection of cold and hot food were available 24 hours a day which included vegetarian, vegan and halal options.

Within the sample of patients' care records we reviewed, we saw that a sepsis[11] screening tool[12] was available within the All Wales National Early Warning Score (NEWS)[13] (patient vital observation charts). Staff were aware of the screening and reporting mechanism for sepsis. The actions required for a patient with sepsis were displayed in the treatment rooms. This aims to identify patients who may be developing sepsis, to ensure that prompt medical review and treatment could be commenced.

Individual care

Planning care to promote independence

Throughout the unit we saw evidence of healthcare professionals promoting individualised care at all times, including tailoring care to patients with specific communication needs.

We found that senior medical and midwifery staff promoted individual care and choices for patients. Birthing partner support was also promoted.

We found that facilities were easily accessible for all people throughout the unit.

[11] Sepsis is a serious complication of an infection. Without quick treatment, sepsis can be life threatening.

[12] Sepsis Screening Tool

[13] National Early Warning Score (NEWS) charts.

We looked at a sample of patient records within the unit and found evidence of individualised care reflected throughout. The care plans also reflected the emphasis on promoting people's independence based on their assessed abilities.

People's rights

We found that family/carers were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. These arrangements were recorded in patients' notes. This was to ensure that all members of the ward team were informed of patient preferences.

Both staff and patients told us that open visiting was available, allowing the partner, or a designated other, to visit between 10am and 8.30pm. Staff also told us that birthing partners could stay with the patient during labour. However, it was noted from further conversations with patients and staff, that some patients felt uneasy when other patients' visitors stayed for long periods of time (including over-night), within the open ward areas. The health board is advised to consider how they can enable open visiting arrangements, whilst protecting the privacy and dignity of other patients on the ward

The hospital provided a chaplaincy service and there was a hospital chapel. On the labour ward, there was a bereavement room available for patients and family, should this ever be required. Due to the current refurbishment work on the labour ward, we were informed that this room was not currently in use. However, staff explained that there were two other rooms available which would be suitable to use if required. The unit had a dedicate bereavement midwife who would manage and lead on any support required.

We were told about arrangements to enable patients from different faiths to access the prayer rooms to meet their spiritual needs.

Listening and learning from feedback

Staff told us there was a Patient Advice and Liaison Service (PALS)[14] team based in the hospital. Their role was to ensure there was an emphasis on obtaining people's views on the care and services provided. We were informed that any

[14] http://www.wales.nhs.uk/sitesplus/863/page/92890

information obtained by the PALS team (whether positive or negative), was shared with ward teams.

Ward managers and staff encouraged patients to provide comments about their care on a monthly basis, which was analysed and appropriate action was taken wherever possible. The You Said, We Did initiative, which highlights changes made as a result of feedback, was used within the unit. Staff who completed a questionnaire said they were aware that patient experience feedback was collected within their ward.

The majority of staff said they received regular updates on patient experience feedback, and felt that it was used to make informed decisions within their area of work. This was reported and seen to be feedback in team meetings. However, there was no clear information displayed to inform patients and families about learning and actions as a result of patient feedback. We advised the health board to consider this.

We found that there was no information displayed about the NHS (Wales) Putting Things Right[15] process on each ward to inform people of how to raise a concern. In addition, Putting Things Right leaflets were not readily available, except by asking staff. This meant that patients and their families did not have clear information about how to raise any concerns they may have. Staff also told us that they did not routinely provide patients with details of the Community Health Council (CHC)[16] who could provide advocacy and support to raise a concern about their care.

Staff told us that communication was maintained with patients and families throughout any concern received, and they were also given the opportunity to meet with senior members of staff to discuss their concerns further. We also saw evidence of feedback being received from the Friends and Family Test[17].

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[15] Putting Things Right relates to the integrated processes for the raising, investigation of and learning from concerns within the NHS across Wales.

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

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

Improvement needed

The health board must ensure that:

- Information is clearly displayed and readily available about how patients and families/carers can raise a concern about their care
- Patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

Delivery of safe and effective care

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

We identified some good processes in place within the unit we inspected, such as robust medicines management and pain assessment.

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

We found that consistency was needed in controlled drug medication checks.

A review of staffing levels, patient acuity in response to the recent reconfiguration of services was needed, including separate staffing requirements for elective caesarean sections.

Safe care

Managing risk and promoting health and safety

We found that the unit was visibly well maintained, clean, appropriately lit and well ventilated. The unit was well organised with a maintained stock of medical consumables. Whilst we generally found that safety was observed throughout the unit, we found a cupboard storing cleaning chemicals, patient identifiable information and also coffee granules which was unlocked and open. This meant that patient identifiable information was not secure. Additionally, there is a health and safety risk with storing foodstuff together with cleaning products. This was raised at the time of the inspection and rectified immediately.

On arrival, we found that due to the current refurbishment of the labour ward, the corridors were cluttered with equipment and beds. However, staff explained this had been risk assessed and was not posing danger to patients or staff. We found the corridors on Ward 18 and 19 to be clutter free and the environment throughout the unit was presented well.

We observed doors were wedged open within the labour ward, meaning that there was a potential risk to the safety of patients and staff in the event of a fire.

This was immediately escalated at the time of the inspection and the doors were then closed.

We also noted upon our arrival to the unit that there appeared to be many patients who had their labour induced, which was detailed on the patient status at a glance board. However, we later found that this did not correlate with the information shown on the newly developed dashboard (Clinical Governance Performance Tool). Whilst we understand that this dashboard is not intended to display live data, we felt there could be a potential for confusion between these sources of patient/information/data.

The number of labour inductions was discussed with the shift co-ordinator and we were assured that they had reallocated staff from within the community to deal with the influx. However, this could have still had an impact on safe care, due to the amount of hours which some midwives told us that they were working, due to reallocation into the acute site, and fatigue they experience during these periods.

We also established from discussions that the leadership of the patient triage element on Ward 19, was not fit for purpose. The senior management team felt that the triage area worked in theory but, staff confirmed that it was not working in practice. During the inspection, we saw a non-clinical member of staff giving pregnant mothers advice over the telephone because the triage midwife was busy, and we were told by the midwife that this was the agreed practice of the triage area. The triage midwife on duty told us that she was also struggling to maintain a positive working balance with the amount of work she was allocated on her own within one shift. We were however advised that a review of the triage system was taking place and this was a priority to ensure safety and appropriate governance was in place.

We found that midwives supported women in recovery after caesarean section surgery. However, staff advised us that they do not receive ongoing training to ensure adequate competencies are maintained. Staff also explained that on occasions, midwives are asked to support the surgical team during procedures (scrub duties), without competencies being maintained appropriately.

Improvement needed

The health board must ensure that:

- Cleaning products and foodstuff to be stored appropriately

- Risks associated with the current refurbishment taking place are assessed, monitored and acted upon to maintain safety.
- Doors continue to be securely closed to maintain safety throughout the unit.
- Labour inductions are managed appropriately with suitable staff available to meet patients' needs
- Ensure that there is consistency and clarity regarding the sources of information relevant to patients, including live information and the use of retrospective data. Any staff performing duties in theatres and recovery are appropriately trained and competent to perform this role.

Infection prevention and control

We found that the clinical areas were clean and tidy. Patients who completed a questionnaire and patients we spoke with said they thought the wards were very clean and tidy.

We saw that personal protective equipment was available in all areas and was being used appropriately by all healthcare professionals. We saw staff complied with infection control policies.

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow. We saw staff washing their hands appropriately and using hand sanitiser gel when needed. We also observed that patient beds were cleaned after each patient use. Medical and midwifery staff were also seen to be adhering to the requirements and practice of bare below the elbow. However, we were unable to gain assurance on audit completion for infection prevention, such as bare below the elbow as they were unable to provide these at the time of the inspection. We were however advised by the senior management team that these are regularly completed by the health board's infection prevention team and reported upon on a monthly basis.

We saw there were designated labels on equipment to signify that it was clean and ready for use. We found that cleaning schedules for the unit were in place and up-to-date.

We were also assured that infection prevention and control training was completed in a timely manner, and any concerns that were raised regarding infection prevention and control would be escalated to senior members of staff.

Nutrition and hydration

Patients who completed a questionnaire, and those we spoke with, said they had time to eat their food at their own pace and that they had access to water. There was also access to hot and cold food outside catering services core working hours, which allowed for nutritional needs being met throughout the day and evening. We saw that all patients had water jugs, and drinks were placed within easy reach where appropriate. Most patients said they had a choice of meals each day and were happy with the food. In addition, patients said they did not have to wait long to be served with their meal.

In the patient care records we reviewed, we found that patient nutritional and fluid requirements were well documented.

Medicines management

In general, we saw that medicines were being correctly and securely stored, including daily checks on the temperature at which medication was stored. Controlled drugs were stored securely and there were recent daily checks (over the last month) in place. However, we found there was one gap in a daily check on controlled drugs on Ward 19. This was immediately highlighted to the senior management team during the inspection. We were told that staff were reminded of the importance and requirement of this procedure being carried out daily. We were also told that this was now included within the daily staff handover meetings to reiterate compliance.

We looked at a sample of medication records and saw these had been completed appropriately. They were consistently signed and dated when prescribed and administered. We observed medication being given to patients on Ward 18 and found that appropriate checks had been carried out by staff to support safe administration of medicines. However, on the labour ward we found that one patients' own medications were not locked away and were left on top of the bedside locker. This was immediately highlighted to the midwife in charge during the inspection. The medication was immediately locked away and we were told that staff had been reminded of the importance and requirement of maintaining safety with easily accessible medications. We were also told that this was now included within the daily staff handover meetings to reiterate compliance.

The unit had a pharmacy technician who would visit daily during working hours to review stock levels. We were told that there was an on call pharmacist available for accessing medicines out-of-hours and this was consistent with the local policy.

All administered oxygen was prescribed appropriately and the administration of oxygen was being monitored and recorded within medication records. Intravenous fluids were appropriately prescribed when required and they were also being monitored and recorded.

The health board medicines management policy was available electronically and also stored in a file on each ward.

Improvement needed

The health board must ensure that:

- Controlled drug medication checks are carried out consistently
- Patients' own medication is stored securely.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who were vulnerable or at risk. Staff had completed training in safeguarding children and adults and were provided with training updates.

Patients said they felt safe and would be comfortable in speaking to a member of staff if needed. We found staff were aware of safeguarding procedures, including how they would report any alleged suspicions or known incidents of abuse.

We saw that the Perinatal Response and Management Service[18] was in place and all staff were appropriately trained and aware of the referral process to follow. The health board did not provide training relating to female genital mutilation, however, staff on shift told us that they were fully aware of how to escalate concerns of this nature.

[18] The Perinatal Response and Management Service (PRAMS) is a specialist NHS team working within the Bridgend, Vale of Glamorgan and Neath Port Talbot areas of South Wales. Working with women with significant stress and other mental health problems around pregnancy and up to a year after birth.

Staff had access to a safeguarding lead who could provide advice and support on safeguarding issues. The safeguarding process was described in detail, demonstrating a multidisciplinary approach between services when dealing with safeguarding issues.

As described earlier within this report, security measures were in place to protect patients within the ward/unit. There were intercom systems used at the entrances to areas to maintain safety around people entering the wards. We also saw that babies were lying on pressure mattresses to ensure their safety on the ward.

Improvement needed

The health board must consider all staff receiving training on female genital mutilation and that staff are aware of the relevant all wales pathway.

Medical devices, equipment and diagnostic systems

Overall, staff we spoke with said they had appropriate equipment available such as sonicaids[19], cardiotocography[20] (CTG) monitors and blood pressure monitoring machines, to help provide care.

We considered the arrangements for the checking of resuscitation equipment on Ward 18, Ward 19 and the labour ward. We were assured that regular checks were being carried out to ensure the equipment was suitable for use.

Effective care

Safe and clinically effective care

Based on discussions with a number of staff across the unit and evidence within staff questionnaires, we highlighted a concern relating to the ability of staff to deliver care in a safe and effective way. We found that staff were often working long hours, over and above normal shifts to help cover shortages. Concerns were

[19] A hand-held device for foetal monitoring

[20] A machine used to record the foetal heartbeat

also raised by staff that there was not the most appropriate skill mix and experience available during all shifts due to the limited availability of staff. However, we were assured there were appropriate systems in place to manage staffing levels alongside patient acuity to ensure safe care at all times and in line with the birth rate plus[21] data.

Whilst we observed staff effectively prioritising clinical need and patient care, due to pressures around staffing levels this affected their ability to complete other duties. This included the completion of identified training, timely and appropriate review of incidents and concerns and carrying out local ward audits.

Whilst reviewing the patient status at a glance board and a sample of patient medical records, we identified areas of improvement. These related to the management of patients requiring an induction of their labour, which is usually carried out when there are health concerns for either the mother or the baby.

We also noted delays in ambulance transfers from community settings and other acute sites into Singleton Hospital. This was highlighted to the senior management team at the time of the inspection, and we were assured that both of these issues were being reviewed and evaluated from the associated incidents raised.

Half of the sixteen members of staff who completed our questionnaires said, they were always or usually satisfied with the quality of care they give, and around a quarter were sometimes satisfied. Less than a quarter of staff said they were never satisfied and one member of staff did not respond to this.

We also noted that the consultant obstetric presence on the labour ward, following recent increase in the number of consultants, is working towards 24 hour a day consultant on-site labour ward cover. This is a positive initiative for the labour ward.

We saw that patients on each ward appeared comfortable and well cared for. We also saw good evidence of medical assessment and treatment plans on each ward. There was a good overall management of pain within the unit, which was

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

seen in the medical records we reviewed and confirmed from discussions with patients at the time of the inspection.

We found that the maternity service had been through a substantial reconfiguration of services in April 2019. As a consequence, the midwifery management structure has been reviewed and the updated structure includes the proposal for a Midwifery Governance Lead. Following the birth rate plus assessment in 2018, the recruitment of 5.8 whole time equivalent midwives and 1.9 whole time equivalent maternity care assistants was approved and recruited to meet the shortfall.

Improvement needed

The health board must ensure that:

- Staffing for medical cover is reviewed to ensure staffing levels are safe and effective to meet the needs of the service
- They advise HIW regarding the work carried out with the Welsh Ambulance Service Trust (WAST) to improve delays in transporting patients to hospital from community settings.

Information governance and communications technology

We found occasions where patient identifiable information was not kept securely to help prevent unauthorised access. Such information was stored within an unlocked cupboard, and we also found a register of births, covering many years, on a table in the midwifery led unit, in clear view of all who entered the ward. The register held confidential details such as date of birth, names and addresses.

These issues were immediately escalated to senior managers and the information was stored away securely. Staff were also informed of the importance of confidentiality.

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and procedures. However, some of this information was found to be out-of-date and requiring review.

We found the unit was using and continuing to develop a maternity dashboard. This is an electronic tool to monitor the clinical performance and governance of

their services. This may also help to identify patient safety issues so that timely and appropriate action can be taken to ensure high quality care. However, we could not be assured that action was taken to follow-up on data which indicated performance was falling below the required level. We also noted that the accuracy of this information could be affected by quality and validity of the data being entered.

Improvement needed

The health board must ensure that:

- Confidentiality is maintained and all patient relevant documentation is stored securely at all times
- All midwifery and medical clinical policies and procedures located within the intranet are reviewed and updated
- The clinical performance and governance system (maternity dashboard) is effectively managed as a tool to support the delivery of safe care. Specifically, the health board must consider and monitor the quality/validity of data and take appropriate action in response to performance indicators.

Record keeping

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

We considered a sample of five midwifery postnatal patient records within the unit. We saw that pain management had been scored and action taken and escalated where necessary. Appropriate risk assessments, including those for deep vein thrombosis, had been completed. However, in some patient records, dates had not always been included on every page, and there were some pages where patient identification labels were not always used. This could cause confusion and risk of inappropriate care being given if patient notes were inadvertently misplaced.

When reviewing the medical records, we found that improvements could be made with record keeping, in line with the results from record keeping audits which were seen and had been carried out by midwifery staff. We found that information governance training was being successfully carried out by staff. We were also advised that there are future plans in place to create one full maternity record, containing all the documents required in one place, which would enable consistency and less duplication.

Improvement needed

The health board must ensure that:

- Patient records include appropriate patient identification labels and dates on each page
- Medical record keeping is reviewed and relevant audit findings influence learning and change.

Quality of management and leadership

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

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

We also found evidence of good leadership and management amongst midwifery and medical teams within the unit. Unit staff who completed questionnaires and those we spoke with, were generally positive regarding the support they received from senior staff. However, we received some mixed feedback about the visibility of senior medical and midwifery staff.

Governance, leadership and accountability

We saw that the service had in place a number of regular meetings to support embedded processes and procedures, which we were advised by senior staff had actively improved services and strengthen governance arrangements. Such meetings included a monthly maternity quality and safety group, bi-monthly audit review meetings, and obstetric clinical review of incident meetings. Additionally, there were monthly ultrasound screening, labour ward, postnatal and neonatal forums, and a weekly multidisciplinary meetings.

They told us that a well-established audit plan for both midwifery and medical staff was in place, with the outcomes of these audits being shared within the bi-monthly audit review meeting. This was then shared via the health board's governance structure into the quality and safety group. In addition, the senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies: Reducing Risk through Audits and

Confidential Enquiries, MBBRACE[22] and Each Baby Counts[23] were taken forward in the unit. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies such as MBBRACE, and ongoing work takes place to ensure the unit is in line with the recommendations made.

We also saw minutes from the obstetrics and gynaecology consultants meeting, team leader and staff meetings. These appeared to be well structured covering many governance areas for discussion. We were advised that a maternity steering group had been established, which would be looking at a planned restructure of the maternity services within the health board. This was underway and the main priority for the group was to improve services throughout the unit.

We were able to attend two medical handover meetings during the inspection. However, we found that the meeting appeared to be dysfunctional with no set agenda or format to follow, and with poor attendance. It was also not in line with the health board's handover guidelines which were in place. Additionally, the handover process was interrupted by the phone ringing to let patients/visitors onto the unit, which staff explained was a regular occurrence.

We saw a maternity risk register which was managed and reported via the health board quality and safety forum. We were told by the senior management team that the executive team were fully appraised and regularly updated of the risks, and any substantial concerns were escalated to them accordingly. However, we found that risks within the register were not regularly reviewed and updated. Midwifery staff also informed us that they were unaware of how to escalate risks to ensure they were included on the risk register appropriately. However this is not in line with the senior managers' understanding, therefore additional training is required to ensure staff are aware of how to escalate risks.

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

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

The health board has a well-structured governance process and electronic system in place for the reporting of incidents. This helps to ensure that all incidents and concerns are dealt with appropriately, along with appropriate scrutiny to ensure that lessons are learned and shared with staff, to minimise the risk of similar incidents reoccurring.

The maternity unit currently has a clinical risk midwife who does not work clinically but can be called upon in times of high acuity (along with other midwives with specialist roles). The clinical risk midwife reviews all Datix submissions of incidents and will allocate responsibility to people who will work on reviews. The clinical risk midwife also works with the matron for assurance of the co-ordination and monitoring of Datix incident reports. We established that the clinical risk midwife will also lead on the investigations for serious untoward incidents as allocated. We were informed that the long term plan is to appoint a service manager who would support the clinical risk midwife and also lead on clinical governance aspect such as Datix and risk management within the unit. We were also advised that on a weekly basis, the senior management team meet to discuss any overdue or concerning incidents or complaints to ensure these are being managed effectively and in a timely manner. Clinical staff told us that a new process was in place for reviewing and investigating any incidents raised and complaints received. This involved, the midwife responsible for risk, allocating responsibility to lead on these to relevant team leaders, for them to investigate further. However, the staff told us that they found it very difficult to complete the investigations within set timescales. We were told that some staff did not have any non-clinical administrative time, and were therefore unable to complete the investigations within a normal clinical shift. Investigation is an important part of the incident management process, to establish how and why incidents or complaints have occurred, with a view to learning and prevention to support the delivery of safe and effective care.

We were advised by the senior management team that learning from incidents, audits together with any good practice was shared with staff. This was through safety briefs, newsletters, incident review meeting minutes, and governance meeting minutes. We saw evidence of the documents during the inspection, however, staff we spoke with said they very rarely see them. In addition, it was unclear to us, that learning was actively shared with staff, to promote and improve the delivery of a safe and effective care.

Improvement needed

The health board must ensure that:

- A more structured approach to medical handover meetings is implemented
- The risk register is reviewed and updated on a regular basis, and all staff are aware of the process for escalating risks
- Staff responsible for investigating incidents have sufficient time to complete the process
- Additional incident/Datix reporting training is carried out to ensure staff are aware of how to escalate risks
- Newsletters and meeting minutes are appropriately shared with staff
- Learning from incidents, audits and good practice is shared effectively with all staff.

Staff and resources

Workforce

As previously mentioned we found that birth rate plus was completed in 2018 which identified a shortfall in midwifery and maternity care assistant roles. The funding for the shortfall was agreed in 2018 and the midwifery posts were successfully recruited to and the maternity care assistants are currently in recruitment. It is recommended that a birth rate plus review is conducted at least every three years. We reviewed both the midwifery and medical rotas. Although there were some staffing issues reported in relation to the acuity, we were told by the senior management team and given assurance that they were managing the deficiencies by working to fill vacant shifts in advance of the date in question.

Medical staff also told us that there were shortfalls in middle grade doctors, but these were adequately managed with locum cover. We were also informed that the medical on call system was also reported to be quite challenging because of the minimum number of staff currently on the rota, but we were advised that this is due to be improved in August 2019 with a full review of staff allocated and the responsibilities they will hold whilst on call. We were informed that efforts have

been made to ensure the job plans of resident obstetrics and gynaecology consultants reflect their gynaecological interests.

Discussions with senior managers demonstrated that there were plans in place to address staffing issues, these included taking the following actions:

- Four hourly patient acuity monitoring by the labour ward co-ordinators
- The recruitment of midwives and middle grade doctors has commenced with a plan to have all in post by September 2019
- Review of governance of triage and the midwifery led unit to ensure adequately staff with the right skill mix
- Paying overtime rather than lower bank rates to staff to encourage them to work additional shifts
- Midwives being brought in from non-acute areas, such as antenatal clinics and the community, to support the acute areas
- Senior clinical managers assisting when able to, to cover shifts
- Improvements to the medical on call rota from August 2019 with a full review of staff allocated and the responsibilities they will hold whilst on call
- Escalation plan followed when unit is found to have high acuity and low staffing levels.

Whilst we felt that health board's actions to address staffing were being managed appropriately, based on our discussions with senior managers, we received a number of concerns from staff. During our inspection, we had the opportunity to speak to a number of staff across the unit, employed in a variety of roles. It was apparent that personal support to colleagues was to a high standard and their appeared to be good relationships between ward staff and the senior management team. However, there appeared to be concern from some staff regarding low morale due to staffing levels and working pressures due to patient acuity.

Staff told us they felt staffing levels had been reduced for some time and this had an effect on staff morale and well-being. We noted several negative comments from the staff questionnaires and the staff we spoke with. Staff referred to difficulties in taking breaks, exhausted with the way they work, and increased workloads. Additionally, staff commented that they work "un-life friendly" shifts,

often in unfamiliar environments with little support. They stated that the working time directive[24] for community midwives working within the unit needs reviewing as many are being called in to cover shifts in the unit when they have already carried out a full day's work in the community setting. Staff also said they had to apologise to patients for delays in inductions of labour, due to staffing shortfalls on labour ward. Furthermore, three members of staff stated that there were never enough staff, to do their job properly.

Only a minority of staff who completed a questionnaire said they were involved in deciding on changes introduced that affect their work, and whilst they knew who their senior managers were, only half believed that communications were effective.

Only half of the staff who completed a questionnaire believed that staff who reported errors were treated fairly, although most agreed they were encouraged to report all incidents and near misses. Half of the staff also said the organisation takes action to ensure incidents won't happen again. However, some staff told us that whilst they received feedback when they had been directly involved in an incident, they felt this was more of a punitive process, rather than as a way to improve. We saw active promotion of the You Said, We Did initiative, to reach out to staff to help inform them of changes they were making in response to staff suggestions. However, based on the feedback from staff, we found that communication was in need of further improvement, especially with regards to the significant changes within the unit.

Whilst we did not speak with community midwives on this occasion, we received feedback from them through our staff questionnaires. Community midwives said they felt unable to carry out their roles effectively because they were routinely called to work in the hospital, due to staff shortages. The midwives also said that they felt they were short staffed in the community when called into the unit, and that they felt the staffing levels had a detrimental effect on patient safety and care.

Staffing within the unit and community was discussed with the senior management team of the unit however, this did not address our concerns with

[24] https://www.gov.uk/maximum-weekly-working-hours

what was said in the questionnaires regarding the detrimental effect on care within the community.

We were assured that where shortfalls in staffing were evident, community staff were called in to the unit. We were also advised by the senior management team that this process was assessed on a regular basis to ensure continuity of care and staff well-being. The management team also confirmed that a substantial staffing intake was due to take place in September 2019, therefore will improve the deficit in staff numbers on shift.

With regards to multidisciplinary working, from the staff questionnaires we received and discussions held, we received positive comments regarding the support and engagement from the anaesthetic team with the midwifery and medical team. We were also advised that there are good working relationships between midwifery and medical staff. Staff we spoke with also commented favourably on the six month community placement in preceptorship, and the preferred place of work scheme that staff believed improved skills and promoted ownership.

We were advised by senior managers that personal appraisal and development review compliance was previously poor, but recent work has been carried out to increase compliance. We were told that there was now a staff appraisal process in place which assisted with determining ongoing training needs however, we found that not all appraisals had been completed, but would have to be completed within the financial year. We gained assurance that support was given to both midwifery and medical staff in relation to clinical supervision and appraisal.

We found that the health board had in place, a sufficient number of supervisors to provide clinical supervision for midwives, and medical supervisors were also sufficient in numbers. However, some members of the midwifery and medical teams told us that more time was required to ensure preceptorship requirements were achieved. One member of staff explained that staffing can often affect preceptorship, and newly qualified staff could be left unsupported during times of high acuity which may have an impact on patient care and staff well-being.

We saw a structured approach to training and clinical supervision with leads in each of these areas managing compliance and uptake. We looked at evidence of staff training held within a database and found that staff were being encouraged to maintain training both mandatory and statutory. Senior managers acknowledged there was greater work needed to ensure training compliance, and that the system/database for training also needs to be consistently updated.

Staff training records were maintained by the practice development midwife who managed training within Neath Port Talbot and Singleton acute and community maternity settings. We were assured from the training database seen, that staff were trained to acceptable levels and requirements in mandatory training, however it was acknowledged that more work was required in this area. We acknowledged the work carried out by the practice development midwife in supporting newly qualified midwives and new staff, and with the development of induction plans. This supported newly qualified midwives in their first year of practice, by developing and underpinning the competencies gained during training. We found this an area of noteworthy practice.

We were told that Practical Obstetric Multi-Professional Training PROMPT[25] training was regularly attended and there was evidence of this. We also noted there was good compliance, above 90%, of mandatory training and the professional update day. This was also confirmed in the staff questionnaires where most staff had undertaken relevant training in the previous 12 months, including Neonatal Resuscitation, Growth Assessment Protocol [26], PROMPT and CTG training.

Senior managers told us that there were robust training plans in place and this was seen to be very well managed by the practice development midwife. However, we noted that training in relation to the midwifery led unit and the appropriate evacuation process during the use of the birthing pool had not been given to all members of the midwifery team meaning that appropriate shift cover was effected due to reduced skill mix. However, we were told by the senior management team that this was appropriately managed with only fully trained staff covering the birthing pools and if no staff available, the birthing pools would not be used which may impact on the limited capacity within the labour ward. This was neither agreed nor disagreed with in any comments received from staff.

[25] PROMPT (Practical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working

[26] GAP/GROWTH Assessment Protocol (GAP) has been shown to significantly increase the detection of Fetal growth restriction (FGR) which is a significant cause of stillbirth, neonatal death and perinatal morbidity.

However, we learnt that a training programme for birthing pool evacuation was yet to be expanded to staff within the hospital.

Improvement needed

The health board must:

- Explore the reasons for low morale and well-being amongst the staff teams
- Review the staffing for both midwifery and medical cover to ensure that staffing levels are safe and effective to meet the needs of the service
- Consider the impact of staffing levels within the community when deploying midwives to work in the hospital
- Explore the concerns raised by staff in relation to delaying induction of labour due to staff shortages
- Ensure training compliance is improved and maintained
- Ensure that communication channels are clearly defined, so staff are fully informed about information or changes that impact on them and their work
- Ensure there are a sufficient number of are trained and available in safe birthing pool evacuation, to support the delivery of care within the midwifery led unit.

4. What next?

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

As a result of the findings from this 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.

5. How we inspect hospitals

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

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

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

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

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

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

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

Appendix A – Summary of concerns resolved during the 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
Please see recommendations in Appendix C			

Appendix B – Immediate improvement plan

Hospital Inspection: Immediate improvement plan

Service:

Area:

Date of Inspection:

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
No immediate improvement needed				

Health Board Representative:

Name (print):

Role:

Date:

Appendix C – Improvement plan

Hospital: Singleton University Health Board

Ward/department: Maternity Services – Ward 18, 19, Labour Ward and Midwifery Led Unit

Date of inspection: 24 to 26 June 2019

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.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that signage at the hospital is reviewed to ensure it is easy to read for all patients and visitors to the hospital.	4.2 Patient Information	Service delivery Unit manager to delegate review of signage with the estates management team for clear signage to maternity departments throughout the hospital	Service delivery unit manager	December 2019
The health board must ensure that notice boards are reviewed to provide health promotion information such as post-natal mental health,	4.2 Patient Information	Matron to order new notice boards for placement in the clinical area on completion of the refurbishment	Midwifery matron Deputy Head of Midwifery	December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
UNICEF baby friendly initiatives and support groups.		Specialist midwives to ensure the content of the notice board is specific to the clinical area		
The health board must ensure that information about staff is displayed for patients.	4.2 Patient Information	Notice board to be placed in the clinical area for Staff information. Photographs to be taken for all Staff and placed on the board during their duty hours	Midwifery Matron	December 2019
The health board must ensure that information is clearly displayed and readily available about how patients and families/carer can raise a concern about their care.	6.3 Listening and Learning from feedback	Stock of Putting Things right leaflets ordered for the clinical areas Ward Sisters to be advised who can replenish stocks of leaflets to maintain the availability of leaflets in the clinical areas	Governance Team Ward Sisters	Completed Completed
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	6.3 Listening and Learning from feedback	Notice board to be placed in the clinical areas to ensure information is clearly displayed and available to support women and families to raise concern including how to contact the Community Health Council	Ward Sister/Estates	December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Information to be placed in all booking packs to inform families how they may raise a concern and provide Community Health Council contact details		
Delivery of safe and effective care				
The health board must ensure that cleaning products and foodstuff are stored appropriately.	2.1 Managing risk and promoting health and safety	Safety notice to all staff of the importance of safe storage of cleaning products and foodstuffs	Midwifery Matron	Completed
The health board must ensure that risks associated with the current refurbishment taking place are assessed, monitored and acted upon to maintain safety.	2.1 Managing risk and promoting health and safety	Monthly Transitional Care Unit (TCU) project board discuss all risk associated with the refurbishment. Management of risks as they present communicated to the Head of Midwifery and Clinical lead and cascaded to clinical teams	Service Delivery Unit Manager/ Head of Midwifery Project Lead/ Head of Midwifery/Clinical Lead	Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		All critical system shutdowns cascaded to the clinical team and risk assessed prior to agreed works	Project Lead/ Head of Midwifery/Clinical lead/ Clinical area managers	Completed
The health board must ensure that doors continue to be securely closed to maintain safety throughout the unit.	2.1 Managing risk and promoting health and safety	Initial immediate feedback from HIW shared with staff at a Unit meeting August 2019 Importance of safety and Infection prevention between Labour ward and theatre to be shared at staff handover for one month to keep doors closed Keypad numbers to be shared with all staff and stored in a secure location in the clinical areas	Head of Midwifery	Completed September 2019 Completed
The health board must ensure that labour inductions are managed appropriately with suitable staff available to meet the patients' needs.	2.1 Managing risk and promoting health and safety	Multi-Disciplinary Team, Induction of Labour working group convened Update IOL guideline to include relevant criteria in line with evidence	Obstetric Governance Lead/ Deputy Head of Midwifery	Completed October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Information leaflet for women to be updated Enhanced red flag monitoring and Datix reporting of all care delivery delays or breach of best practice standards (NICE, RCOG)		October 2019 October 2019
The health board must ensure that there is consistency and clarity regarding the sources of information relevant to patients, including live information and the use of retrospective data.	2.1 Managing risk and promoting health and safety	Data information lead to liaise with Singleton Service Delivery Unit Business Hub to continue work on the maternity Dashboard for information to be as current as possible through electronic transfer of data for fields where this is possible	Data information lead/Business Hub SDU	December 2019
The health board must ensure that any staff performing duties in theatres and recovery are appropriately trained and competent to perform this role.	2.1 Managing risk and promoting health and safety	Multi-Disciplinary Team working group convened to • review 24/7 theatre team cover for obstetrics • introduction elective caesarean section list fully staffed by theatre team to be included in the IMTP due to financial impact	Surgical services Directorate manager Head of Midwifery	Completed September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• Theatre issues to be presented at Singleton Hospital Service Delivery Unit Quality & Safety meeting for acceptance to Risk register	Professional Development midwife	January 2020
		• PROMPT training provided for all maternity staff annually- 1st year reporting in January 2020. Training attendance currently on target to achieve >90%	Training and education Forum	December 2019
		• Training needs analysis using self-assessment to be completed by all relevant staff in relation to theatre and recovery of women following operative birth	Training and Education Forum	January 2020
		Findings of training needs analysis to be incorporated into a fourth mandatory training day (Swansea Bay University Health Board currently provide three mandatory training days per annum for midwifery staff) to include care in recovery following spinal/epidural and post-surgical care.		

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that controlled drug medication checks are carried out consistently.	2.6 Medicines Management	Monthly assurance audits completed With relevant actions completed for assurance of safe practice	Head of Midwifery	Completed
The health board must ensure that patient's own medication is stored securely.	2.6 Medicines Management	Use of Self-Administered Medication System (SAMS) to be used effectively and audited and monitored for compliance Midwife to take responsibility for patient own medication where a locked cupboard is not available for SAMS. Safety brief circulated.	Midwifery Matron Midwifery Matron	December 2019 Completed
The health board must consider all staff receiving training on female genital mutilation and that staff are aware of the relevant all wales pathway.	3.1 Safe and Clinically Effective care	All staff employed in 2017/18 received education update for female genital mutilation on the annual mandatory training programme Female genital mutilation management training to be included in 2020/21 programme (three year cycle)	Head of Midwifery	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Named Lead Obstetrician for management of care for women who have experienced female genital mutilation within the Health Board.		
The health board must ensure staffing and medical cover is reviewed to ensure staffing levels are safe and effective to meet the needs of the service.	3.1 Safe and Clinically Effective care	Medical staffing is monitored in line with RCOG standards. The Health Board is fully compliant Midwifery staffing is monitored in line with BR+. The Health Board is fully compliant.	N/A	N/A
The health board must ensure that a review of the establishment is carried out to ensure appropriate staff are in post, which would ensure that completion of mandatory/other training, incident/concerns investigation and audits can take place.	3.1 Safe and Clinically Effective care	Birth Rate plus (BR+) will be undertaken between October and December 2019 to ensure the Health Board remains fully compliant. Staff attendance at mandatory training days is monitored through the year and reported annually- Compliance for 2018/19 was > 90% attendance	Head of Midwifery Training and Education Forum	December 2019 March 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Performance management for incident reviews and complaints is monitored and reported through the Singleton Hospital Service Delivery Unit Quality and Safety meetings with escalation and oversight by Executive Board.	Service Delivery Unit Management team/Executive Board	Completed
		Governance team resource to be reviewed during the restructure of maternity services within the Health Board. The governance resource remains Amber on the Swansea Bay University Health Board self-assessment against the findings of the Maternity Service Report for Cwm Taf University Health Board	Service Delivery Unit Management team/Head of Midwifery	December 2019
The health board must advise HIW regarding the work carried out with the Welsh Ambulance Service Trust (WAST) to improve delays in transporting patients to hospital from community settings.	3.1 Safe and Clinically Effective care	Consultant Midwife leading on communications with Welsh Ambulance Service Trust to reduce the transfer times from the Neath Port Talbot Birth Centre and Community settings to ensure the safety of mother and baby.	Consultant Midwife/ Welsh Ambulance Service Trust/ Head of Midwifery	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Transfer Map developed for information to all relevant staff Vicky SBAR embed Presentation of SBAR to Singleton Hospital Service Delivery Unit Quality & Safety meeting to review risk rating and upgrade (current risk score 12)	Consultant midwife Service Delivery Unit Management team/Head of Midwifery	Completed September 2019
The health board must ensure that confidentiality is maintained and all patient relevant documentation is stored securely at all times.	3.4 Information Governance and Communications Technology	IG information included in September newsletter Feedback from HIW report presented at unit meeting • initial findings • full report (on publication) Posters to be placed in clinical areas for Information Governance guidance	Clinical Supervisor for Midwives Head of Midwifery Midwifery Matron/Governance administrator Ward sisters	Completed Completed October 2019 October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Notes trolleys stored in staff only areas Incident reporting of all IG breaches.	Head of Midwifery	Completed Completed
The health board must ensure that all midwifery and medical clinical policies and procedures located within the intranet are reviewed and updated.	3.4 Information Governance and Communications Technology	All staff made aware of how to access policies during their induction programme Chairs of clinical forums provided with a list of out of date policies for review or archive if no longer relevant	Training and education Forum Governance administrator /Clinical Forum Chairs	Completed September 2019
The health board must ensure that the clinical performance and governance system (maternity dashboard) is effectively managed as a tool to support the delivery of safe care. Specifically, the health board must consider and monitor the	3.4 Information Governance and Communications Technology	Dashboard in development to ensure quality/validity The data administrator is a member of the governance team and has six hours for data management within the role. The Six hours for data management will	Data information lead/Business Hub SDU Singleton delivery Unit management	October 2019 December 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
quality/validity of data and take appropriate action in response to performance indicators.		be protected to improve data management and upkeep of the dashboard. Risk linked to overall governance resource as this will further reduce governance resource further. Agenda at September Singleton Hospital Service Delivery Unit Quality & Safety meeting Maternity dashboard to be presented at each Assurance and learning meeting, Audit session, consultant and professional midwifery forum for wider sharing with the teams	team/Head of Midwifery Clinical Obstetric Lead/Head of Midwifery/Audit lead	October 2019
The health board must ensure that patient records include appropriate patient identification labels and dates on each page.	3.4 Information Governance and Communications Technology	Share HIW findings through professional meetings and newsletter circulate a safety brief to all relevant maternity staff to remind of the importance of patient identification and dates on every page of records.	Deputy Head of Midwifery	September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that medical record keeping is reviewed and relevant audit findings influence learning and change.	3.4 Information Governance and Communications Technology	Include in annual record keeping audit - the question that patient identification information and date are visible on every page in records.	Deputy Head of Midwifery	March 2020
Quality of management and leadership				
The health board must ensure a more structured approach to handover meetings is implemented	Governance, Leadership and Accountability	Review the current Multidisciplinary handover and facilitate implementation of a more effective handover. Following the change effectiveness to be audited. Ensure clerical support is available during handover to prevent disruptions of phone calls and answering buzzers from women/relatives trying to gain access to labour ward during this time. Consultation currently underway with Human resources to change working locations of ward receptionists to ensure 24 hour reception cover on Labour Ward in line with the Royal College of Obstetrics and Gynaecology recommendations	Clinical lead Obstetrician for labour ward/ Intrapartum lead for labour ward Midwifery matron	January 2020 October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure the risk register is reviewed and updated on a regular basis and that staff are aware of the process for escalating risks	Governance, Leadership and Accountability	Monthly risk register meeting Presentation of maternity risk register at Health Board Quality & Safety forum Highlight importance of escalating risks for inclusion on maternity risk register in professional midwifery forum, Consultant meeting and newsletter. Governance team present to all staff at induction.	Clinical Lead/Head Midwifery/Executive Board Clinical Lead/Head Midwifery	Completed September 2019 Completed
The health board must ensure that staff responsible for investigating incidents have sufficient time to complete the process.	Governance, Leadership and Accountability	Identified governance resource gap which has been escalated to service delivery unit to address within maternity structure review. Present at September Singleton Hospital Service Delivery Unit Quality & Safety meeting	Service Delivery Unit Management Team Head of Midwifery	September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that additional Datix/incident reporting training is carried out to ensure staff are aware of how to escalate risks.	Governance, Leadership and Accountability	Agree presentation for update Datix training to evidence the link to the risk register in 2020/2021 mandatory training programme.	Deputy Head of Midwifery/ Training Education Forum	December 2019
The health board must ensure that newsletters and meeting minutes are appropriately shared with staff.	Governance, Leadership and Accountability	Learning from incidents, audits and good practice is shared via risk newsletter, safety briefs, and feedback from monthly risk meeting to all staff. Undertake a small review of what staff recall from the learning and good practice communication to monitor effectiveness	Clinical Supervisors for Midwives/educational supervisors (doctors)	December 2019
The health board must ensure that learning from incidents, audits and good practice is shared effectively with all staff.	Governance, Leadership and Accountability	Learning from incidents, audits and good practice is shared via risk newsletter, safety briefs, and feedback from monthly risk meeting to all staff. Undertake a small review of what staff recall from the learning and good practice communication to monitor effectiveness	Clinical Supervisors for Midwives/educational supervisors (doctors)	December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must explore the reasons for low morale and well-being amongst the staff teams.	7.1 Workforce	Ensure staff are aware of wellbeing service through Personal Appraisal Development Review (PADR) process Highlight importance and encourage participation in All Wales staff survey Guardian system rolled out in health board. Highlighted their service in Professional midwifery forum for band 7s to share with staff they manage. Guardian information on health Board intranet site Request to Clinical Leaders to feedback request for greater visibility in the clinical areas. Uniforms ordered by Matrons Clinical Midwife asked to lead on a confidential exercise asking all staff to provide comments/ suggestions for service improvement in their place of work. Meeting arranged to feedback findings and plan actions in partnership	Head of Midwifery/Clinical lead Midwifery Matron	Completed Completed Completed Completed
The health board must review the staffing for both midwifery and medical cover to ensure that	7.1 Workforce	BR+ last completed in 2018. Being repeated in 2019 (October – December	Head of Midwifery	December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
staffing levels are safe and effective to meet the needs of the service.		in light of boundary change to highlight if there any deficiencies in the midwifery staffing of the unit Obstetric staffing in line with Royal College of obstetricians and gynaecologists standards. 4hrly acuity on labour ward is undertaken to highlight any shortfalls in staffing for clinical need.	 Labour ward co-ordinator	 Completed Completed
The health board must consider the impact of staffing levels within the community when deploying midwives to work in the hospital.	7.1 Workforce	Consultation planned with all midwives to review on-call systems, shift patterns in community and annual leave management. Meeting with human resources to support and plan the process has taken place August 2019 Robust supportive sickness management in line with maintaining attendance at work policy	Head of Midwifery Midwifery matrons/obstetricians	March 2020 Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
Explore the concerns raised by staff in relation to delaying induction of labour due to staff shortages	7.1 Workforce	Multi-disciplinary team 'induction of labour' working group convened Update IOL guideline to include relevant criteria in line with evidence Information leaflet for women to be updated Enhanced red flag monitoring and Datix reporting of all care delivery delays or breach of best practice standards (NICE, RCOG)	Clinical lead/Deputy head of midwifery	Completed October 2019 October 2019 October 2019
The health board must ensure training compliance is improved and maintained.	7.1 Workforce	Training compliance for Midwifery staff was > 90% compliant in 2018/2019. Monitoring of attendance is ongoing through 2019/2020 Mandatory e-learning currently 50%. Additional fourth mandatory study day planned for 2020/21 which will include booking of learning laboratory (computer hub) to provide staff with time to complete e-learning requirements.	Training and education Forum Training and education Forum	March 2020 September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Practice development midwife to book ad-hoc sessions in learning laboratory computer rooms until March 2020 to commence the process		
The health board must ensure that communication channels are clearly defined, so staff are fully informed about information or changes that impact on them and their work.	7.1 Workforce	Provide regular team and unit meetings to ensure staff have the opportunity to learn about changes that may impact on their work. AAU /ADAU guidelines to be uploaded to WISDOM for all staff to be clear on referral criteria.	Head of midwifery/Clinical lead Governance team	Complete September 2019
The health board must ensure there are a sufficient number of are trained and available in safe birthing pool evacuation, to support the delivery of care within the midwifery led unit.	7.1 Workforce	Training plan agreed and in place for the multidisciplinary team on use of pool birth and safe evacuation in an emergency. 1st session provided September 2019	Consultant midwife	September 2019

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: