# Freedom of Information Request – ATISN 18828

# 1. Notes from internal HIW intelligence meeting

#### 24/03/2022

Swansea Bay, NPT birthing centre maternity services still closed but have a plan in place due to open end of May.

#### 28/04/2022

#JusticeForXX on Twitter: "Maternity thread: Our son XX was born @ Singleton Hospital in @SwanseabayNHS in XX. Through gross negligence he was left with major brain injury. 3 months later @HIW_Wales 'highlighted a concern relating to the ability of staff to deliver care in a safe & effective way'" / Twitter	SBUHB	Both HIW and SBUHB were tagged in a number of tweets, relating to low staff numbers and concerns in the health board. Our inspection report on Singleton hospital was also linked in the thread.
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

#### 24/11/2022

**Local Themes** 

Swansea Bay

• The Welsh Government has demanded a critical maternity review into the birth of a disabled boy in Swansea be handed over by the health board.

#### 09/03/2023

XX on Twitter: "We met @WelshGovernment on 21st Nov to set out Maternity concerns @SwanseabayNHS. @WelshGovernment Briefing Note from week later lays out their concerns on it. They suggest @NHSWalesDU & amp; @HIW\_Wales investigations. Yet 15 days later they write to Swansea saying no investigation.

#### 16/03/2023

SBUHB - 4		
SBUHB	Concern regarding maternity	Medium
	services at SBUHB and a	
	report regarding the service.	

Swansea Bay - concern re maternity services. XX dealing with this. Quoted a certain report done by a professor back in 2021 they are asking to meet with us to share the SI's they have and their concerns.

#### 08/06/2023

MBRRACE-UK: 2021 Report Key Findings for Welsh Local Health Boards

An early release of the findings from the report were published on 16 May 2023 and can found here: https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/

- Sharp increase in neonatal mortality rate for Swansea Bay between 2020 and 2021. Around 26% higher than group average in 2021.
- Swansea Bay extended perinatal mortality rate consistently higher than group average. In 2021, around 9% higher than group average.

XX- Swansea Bay maternity concerns were previously - worth speaking to XX about this. We need to get neonatal methodology sorted. This has been on our radar and more coming out of that information re neonatal rather than maternity.

#### 2. Query received from member of the public - 24/11/2022

XX,

Apologies for not replying to your email sooner.

HIW plans inspections on an annual basis. We consider numerous information sources to identify the highest risk areas for us to inspect. For example, serious incidents information, concerns through our website etc. We also respond during the year to new risk areas. We do not specify that services will always be inspected within certain timeframes.

For information, we inspected Singleton Hospital Maternity services, and Neath Port Talbot Hospital Maternity services in 2019/20. The reports are <a href="here">here</a> and <a href="here">here</a> and <a href="here">here</a>.

You can report concerns to us on our website here.

Please let me know if there is anything else I can help with.

XX

Hello

I just wanted to guery how often do you inspect services such as Swansea Bay Maternity Services?

Thank you

XX

# 3. Email between HIW staff following meeting between HIW and Swansea Bay Health Board – 13/06/2023

Hi XX

Caught up with XX last week – I just thought I'd pop a few small notes into an email for you so that we're both on a similar page:

- XX
- XX
- His worry list:
  - Maternity and staffing: having daily staffing meetings. 13 midwives is the not ideal, but 'safe' number required each shift. Sometimes go below this and report by exception on these cases. Feels things are ok otherwise. Re-iterated plans to re-open NPT eventually.
  - $\circ$  XX
  - o XX
- MBRRACE report (see latest weekly intel doc attached for some interesting stats re: SBUHB and neonates) XX said that the team had done a review on the back of this, including responses to WG, and that Improvement Cymru are undertaking a review of all maternity units also. I re-iterated the potential usefulness of a neonate methodology to XX and XX.
- XX

XX

## 4. Internal HIW meeting notes from monthly Risk & Escalation Committee

## February 2022

 Maternity Services – still centralised – Neath Port Talbot hope to reopen in February – waiting confirmation.

## June 2022

• Maternity – Unit in Neath Port Talbot remains closed.

## **July 2022**

• Singleton Maternity – safe care being provided – Midwife Unit is still closed.

#### September 2022

- Midwife led maternity unit remains closed with no current plan to reopen due to lack of midwifery staff.
- Concerns received from whistle-blowers that there is an unsafe level of midwives on duty. The number of staff not to drop below 13 and has dropped.

## January 2023

• Birthing Unit unlikely to open in January

## February 2023

 Birth centre remains closed and is unlikely to open – continue to use centralised site at Singleton.

#### March 2023

• No current plans to reopen the neo-birthing unit due to inability to safely staff.

## **July 2023**

- Maternity and Neo Natal remains firmly on the radar with moderate to high level risk.
- 5. Freedom of Information request responded to in October 2022

## FOI release 16687: Maternity services | GOV.WALES

6. Meeting notes from internal HIW senior management meetings

## 18/07/2022

SBUHB, Maternity: staff shortages.

#### 28/11/2022

# 7. Letter to Swansea Bay Health Board re Healthcare Inspectorate Wales National Review of Maternity Services - 15 June 2023

Dear XX,

Healthcare Inspectorate Wales National Review of Maternity Services.

As you are aware, Healthcare Inspectorate Wales (HIW) published a report for its phase 1 national review of Maternity Services on 19 November 2020.

The report made 32 recommendations for all Health Boards to consider and act upon. Following your initial action plan submitted in 2021, we are now requesting a further update on the progress made with your actions in response to the report recommendations, as part of HIW's review follow-up process. This is to help us consider the work undertaken by the organisation and the sustainability of implemented actions, since the review report was published in 2020.

Please provide us with a full update by no later than Friday 30 June 2023.

Following our evaluation of your previous and latest action plans, we will draft a Review Impact Summary which will be published on our website in due course.

Enclosed is a copy of the table of recommendations which were highlighted within the review report.

If you have any queries or concerns about the content of this letter, or the submission date provided, please e-mail HIW.reviews@gov.wales or telephone 0300 062 8163.

Yours sincerely,	
XX XX Healthcare Inspectorate Wa	ales
Cc. XX. XX	

XX, XX XX. XX

8. HIW email to Swansea Bay Health Board confirming extension to deadline of Maternity Review response

Good morning XX

Further to our telephone call reference the Swansea Bay Maternity Review. Just to confirm that XX has agreed an extension for you to send in your return to us no later than 12 July 2023.

Kind Regards

XX

9. Information from HIW Healthcare Summits

Following Comments from May 2023 Summit in reference to Maternity Services:

XX - Around 50% of midwifery workforce is agency- currently recruiting internationally (concerns around racism and function with little support however SBUHB will put together rigorous induction process)

XX - concern over midwife staffing in maternity services

HIW - no mat services in NPT due to staffing

## Following Comments from November 2022 Summit in reference to Maternity Services

HIW - Maternity services in SBUHB, reported in last summit, still closed. Struggling to maintain staffing at Singleton and no ability to open in foreseeable future.

XX - Home Births still suspended- due to lack of midwives

XX - NPT maternity unit closed. Not delivering a service to patients. Midwife led model of care / IPC agenda – have plans in place but not coming to fruition. Maternity risk – leadership and staffing a risk.

XX - 20-25 score for maternity on risk register. Escalated to WG.

XX - From WP perspective echo the themes noted. Maternity PROMPT training is on track but Community PROMPT implementation is more sporadic

## Following Comments from May 2022 Summit in reference to Maternity Services:

HIW - Neath Port Talbot midwife led unit remains closed. Six midwives short of a sufficient establishment to reopen. Open about the need to centralise to ensure safety of the service but continue to work to return to BAU as soon as possible.

#### 10. HIW contribution to joint meeting with Welsh Government July 2023

Through our assurance work and intelligence gathering functions, including the RM role and HIW concerns processes, there are key risks affecting the health board which require further monitoring and consideration. These include:

• Maternity: staffing, provision and access, and neonatal care

Intelligence to note -

- Moderate to high level of RM concern regarding maternity and neonatal services:
- Critical midwifery staffing levels at Singleton Hospital Risk to patient safety
- Suspension of home birth service and Neath Port Talbot Birthing Centre Risk to patient / mothers choice and experience

Health Board owned risks - Risk Register:

- Screening for Fetal Growth Assessment red risk increased risk due to insufficient ultrasound capacity within SBUHB to offer all women ultrasound in third trimester in line with GAP (Growth Assessment Programme). GAP compliance at 58% as of 25/4/2023.
- CTG (cardiotocograph) red risk misinterpretation of CTG's and failure to take action is leading to poor outcomes in obstetric care
- Delay in induction of labour amber risk reduced from red risk. Delays can introduce avoidable risk and unnecessary intervention which can lead to poor clinical outcomes.

A breadth of service changes have taken place / are taking place as a result of the pandemic and its recovery. Reasons include the need to review clinical capacity due to staffing challenges, and the need to increase elective capacity in tackling the planned care waiting lists.

Examples include the suspension and centralising of maternity services at Singleton, establishment of an adult inpatient single point of access at NPT, and the centralising of older persons mental health away from NPT:

This is being monitored by the RM. Whilst these changes intend to provide a resilient service for patients, it also presents a potential risk to patient experience, governance, and staff morale, with an unknown degree of impact (if any) on care and treatment pathways.

## 11. Ombudsman reports

Ref: 202003081- Clinical treatment in hospital: Swansea Bay University Health Board (ombudsman.wales)

Ref: 202005974- Clinical treatment in hospital: Swansea Bay University Health Board (ombudsman.wales)

## 12. Notes from meeting between HIW and Welsh Government – 24/11/2022

Topic: SBUHB Maternity

Context: SBUHB XX has asked whether HIW would inspect SBUHB as part of any phase 2 of the national maternity review

Clarified with XX that there is no phase 2, and this has been a misconception by the service that HIW will seek to clarify. There have been, and will be risk-based inspections of maternity services, but not as part of formal review / stage 2

XX set context of SBUHB's request

Relates to a slightly historic review of Community Children Nursing (CCN) families. At time HB took corrective and restorative actions in relation to issues highlighted by this review.