Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Neath Port Talbot Hospital Birth Centre,

Swansea Bay University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Neath Port Talbot Hospital Birth Centre, Swansea Bay University Health Board on 4, 5 and 6 February 2025.

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

During the inspection we invited women and their families to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. In total, only two responses to both surveys were received which contained limited information. This report includes feedback received from discussions with staff we spoke to during our on-site inspection.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

We witnessed staff welcoming women who attended the Birth Centre with care, kindness and respect. We found the staff worked well as a team to provide women and birthing people with a positive experience that was individualised and focussed on their needs. All women and birthing people received their care in a welcoming and homely environment.

This is what we recommend the service can improve:

- Ensure that healthy lifestyle information is available to help support women and their baby while they are pregnant
- Consider improving the hospital signage to the Birth Centre to help direct women and their birthing partners to improve their overall experience.

This is what the service did well:

- Feedback captured from women by the health board reported excellent feedback from services provided at the Birth Centre
- We witnessed staff welcoming women who attended the Birth Centre for routine appointments with care, kindness and respect
- Plans to develop in-reach work for further engagement and promotion of the Birth Centre in diverse and more deprived communities to increase the diversity of birthing people and families who use the centre.

Delivery of Safe and Effective Care

Overall summary:

We saw robust arrangements were in place to provide women with safe and effective care. We were assured that safe and effective care was delivered to women and babies using this service. There were processes and audits in place, to manage risk and health and safety. The standard of record keeping was good and promoted appropriate choices for women. Records were clear, legible and well organised. We found there were clear processes in place for the management of

clinical incidents, ensuring that information and learning is shared across the service.

This is what we recommend the service can improve:

- The health board must conduct a baby abduction drill at the Birth Centre and associated learning from the drill should be shared with staff members.

This is what the service did well:

- Clear and well communicated processes and criteria were in place to mitigate risk and ensure that women who wish to birth at the centre fall within the strict criteria and guidelines
- The implementation of an E- community digital workbook is notable practice that aligns with the lone worker policy and assists with sharing of the case load to ensure that no calls are missed
- Effective systems and policies were seen and described to us by staff for the management of medical emergencies.

Quality of Management and Leadership

Overall summary:

A management structure was in place with clear lines of reporting and accountability. Managers were visible within the Birth Centre and comments say that they were approachable, friendly, kind and supportive. We saw well-functioning teams in place and given the that the service has recently re-opened after a long closure there is an acceptance that processes may need change on the back of staff or patient feedback and leaders are not afraid to propose changes.

This is what we recommend the service can improve:

- Ensure that arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018 are maintained at all times.

This is what the service did well:

- A daily safe staffing safety huddle took place which enabled constant scrutiny of the establishment

- Staff reported that they were encouraged to escalate if there were capacity issues. We saw that staff felt psychologically safe to challenge leaders appropriately and demonstrate a supportive and positive work environment

- Staff felt confident that they can raise concerns appropriately and spoke about a positive culture around Datix reporting and learning from incidents.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection, we received only one response to our questionnaire to obtain views from women and families. We were unable to seek views in person, as no birthing women or their partners were present at the Birth Centre during our inspection. We have, however, seen evidence of multiple ways that women and their families can feed back on their experience.

We reviewed the health board Birth Centre Patient Experience Report undertaken by the health board. This captured patient experience feedback from a total of 24 women and family since the reopening of the unit in September 2024 up to 31 January 2025. The survey returns had an overall score of 96% and highlighted excellent feedback from women and families that had used the Birth Centre. This included positive comments about the skill and professionalism of the midwives and staff, along with the environment.

Comments within the Birth Centre Patient Experience Report included:

> *"All the staff were amazing from start to finish. The room was spotless, so welcoming and made me feel at ease/calm. The spacious private rooms after birth are amazing for mum and baby."*

> *"The support received by midwives and the team was absolutely fantastic. I could not have felt any safer than I did when I was in the hospital."*

> *"The midwives were amazing for my first birth, the experience was calm, the birthing pool was amazing, and I couldn't have had a better experience for my first labour. I will 100% be going to the birthing centre should I have another child in the future."*

As part of our inspection, a member of the HIW inspection team spoke to a representative from the Swansea Bay Maternity Voices Group. Their role is to engage with the local community and leaders to understand service users' experiences and needs. The discussion highlighted the positive feedback the Group had received from women following their experiences at the Birth Centre. We were also informed that a Patient Experience Forum had been set up to enable a more holistic approach in achieving outcomes to improve services.

Staff told us that the Maternity Voices Group had worked hard to improve maternity services within Swansea Bay health board area. However, challenges had been faced in achieving the desired outcomes from the feedback received from the public due to a lack of available resources. We were told that a Patient Experience Midwife was being recruited, and that part of their role would be to improve the monitoring process of the Group's action plan working alongside the Maternity Voices Group Partnership. The Patient Experience Midwife will also have a managerial role to ensure that there is a more robust system to complete actions for Patient Experience plans. The role would also amplify women's voices and ensure that the services provided meet their needs.

Within the Birth Centre, we saw that Friends and Family "Have your say" leaflets were available in both Welsh and English. This enabled women and birth partners an opportunity to feedback on their experiences.

Person-centred

Health promotion

We reviewed health promotion information displayed within the Birth Centre. Information available to women and their partners included smoking cessation, breast feeding, immunisation and sexual health. This information was available in English and in Welsh. However, there was a lack of information on healthy eating, physical activity and information for carers. **The health board should ensure that healthy lifestyle information is available at the birth centre to help support women and their baby while they are pregnant.**

We reviewed extensive online information for women and birthing people on the health board website. This included pregnancy and health promotion information. This information was available in English and Welsh. A facility is available to translate information on the health board website to a language of choice. We were told that maternity services within the health board are working towards implementing 'open access' to all women who are unable to converse in English throughout their pregnancy.

We were informed that an Infant Feeding Midwife Co-ordinator is in post at the Birth Centre. Midwives and Maternity Care Assistants are given appropriate training to support women with breastfeeding. These groups are run by staff as well as volunteers.

Dignified and respectful care

The unit was quiet during our inspection and the inspection team were not able to witness face to face care. However, throughout the inspection we witnessed staff

welcoming women who attended the Birth Centre for routine appointments with care, kindness and respect. We also witnessed respectful interactions with staff during telephone conversations.

All birthing rooms were well appointed, clean and had a ‘home from home’ feeling to provide a relaxed environment for women and their birthing partners. The unit had a mural painted on a wall, and rooms had positive and powerful pregnancy affirmations, which included,

> “*Birth is powerful, and so am I*”.

Rooms had a shared bathroom connecting two rooms, and processes were in place to ensure that privacy, and women’s dignity was maintained when using the bathroom. The birthing rooms have doors and curtains to provide privacy. The postnatal beds are double beds and partners are welcomed to stay overnight if needed to support women and their babies. Tea and coffee making facilities were available in the rooms.

We saw that medical devices were discreetly hidden in drawers and behind blinds to maintain a homely environment.

Individualised care

The re-opening of the Birth Centre in September 2024 provided women and their birthing partners an additional choice for their birthing experience within the health board area. Patient feedback, highlighted earlier in the report, reflected the positive experience of birthing women and their partners at the Birth Centre. This was supported through discussion with staff who demonstrated their passion and positivity in the re-instatement of the Birth Centre.

Staff we spoke with demonstrated a good awareness of their responsibilities in protecting and promoting women’s choices within the health board criteria and national guidelines for birth centre births. We were told that information leaflets for key aspects of pregnancy and labour are provided, and birth discussions take place at 36 weeks and should be ongoing at each antenatal assessment. Where necessary, women are referred to the Consultant Midwife for personalised care plans. Examples were shared with the inspection team of comprehensive patient care and discussion around need.

A system was in place to immediately highlight a woman’s preferred language in their records. Staff told us that language line is used for all contact where required, and face to face interpreters are offered for intrapartum care. They also offer sign language via language line.

We were told of a recent Maternity Voices partnership initiative launched at the Birth Centre to support discussions about the birth options and choices available to parents and help them to make informed decisions.

Parentcraft classes are offered at the Birth Centre. The classes provide an opportunity for women and their birth partner to attend and help them prepare for labour and the birth of their baby. Midwives provide a tour of the unit to promote it as a birth option for those who fall within the birthing guidelines, and to assist people and their birth partners in making informed choices about their birth options.

Staff described to us their ambition to further develop the Birth Centre as a centralised Hub, bringing services closer to communities and ensuring safe antenatal and post-natal care. We were told that consultant clinics take place at the Birth Centre, and that sonography appointments are also offered. The vision is for the hub to include additional facilities such as new-born screening.

Timely

Timely care

The Birth Centre is open and staffed 24 hours a day and can be accessed by women that meet the health board criteria for birth centre birth.

The Birth Centre has clear guidelines and procedures for transfers of care in a timely manner to an obstetric unit, in line with national guidelines. We reviewed documentation within the unit detailing transfer times from the Birth Centre to an obstetric unit. We were assured that transfers were integrated into WAST priority systems and undertaken in a timely manner. Discussions with staff also confirmed positive working relationships with obstetric unit staff in consulting and preparing for transfers of care.

We reviewed the All-Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units on Wisdom. Wisdom is an All-Wales information system for Obstetrics, Gynaecology and Midwifery. This guideline, developed by the health board, originated from transfer options based on risk used within Swansea Bay University Health Board. We were told that this work was shortlisted for a Royal College of Midwifery award in 2024. **We saw this as noteworthy practice.**

A system was in place for recording and reviewing all transfers of care from the Birth Centre to the Obstetric unit. Transfer times were monitored and any transfers “out of pathway”, for example poor AGPAR score, were recorded on the Datix system. It was explained that any transfer delay would be reported to the maternity services Quality and Safety lead for lessons learned and/or missed

opportunities. Any departmental concerns would be escalated, and any transfer delay will be reported, managed and investigated.

A monthly transfer review meeting takes place, and it was positive to note that a representative from WAST is present. **This is highlighted as noteworthy practice as it enables better communication and an opportunity for joint learning.**

Senior staff told us of discussions taking place with WAST to ensure availability of a WAST vehicle for transfers to provide a more consistent, efficient transfer service when required

We reviewed three sets of clinical notes of women who had been transferred from the Birth Centre to the Obstetric Unit at Singleton Hospital. We noted positive, timely transfer times, appropriate escalation when acuity was high with WAST, and good outcomes for all women and babies. Notes reflected that Birth Centre staff were well supported with positive and regular communication between the midwives at the Birth Centre and the Coordinators in Singleton, to ensure that everyone was aware of the acuity in all settings.

We recommend that the health board should continue to focus and further refine options and processes for safe transfer of women from the Birth Centre to higher acuity care. This will ensure that all parties continue to be aware of any emerging issues with transfers.

We reviewed patient care records that confirmed that patients were regularly checked for personal, nutritional and comfort needs. We considered how women and birthing people were supported to manage their pain and were informed of several pain relief options appropriate to a Birth Centre which were readily available in a timely manner.

Equitable

Communication and language
We reviewed signage for people arriving at the Birth Centre. We observed there was only limited signage on display which was too small to be easily noticed. **The health board should consider improving the hospital signage to the Birth Centre to help direct women and their birthing partners to improve their overall experience.**

Welsh language speaking staff within the Birth Centre were identifiable through the “iaith gwaith” logo. Bilingual information was also seen on patient information boards throughout the unit as well as on the health board website. This ensured that care through the medium of Welsh is actively offered to women and families.

Staff told us that language line is used for all contact where required, and face to face interpreters are offered for intrapartum care.

Discussions with staff identified mechanisms that were in place to overcome language barriers, mental health problems, or learning difficulties. Plans would be put in place to support women and their birthing partners, and appropriate support would be provided. Women who experience mental health problems that wish to birth at the Birth Centre are referred to the Perinatal Mental Health Specialist Midwife who would develop a personalised plan.

We were told that the Birth Centre is offered as an option to all birthing people who fall within the birthing criteria and guidelines. Staff told us of plans to develop in-reach work for further engagement and promotion of the Birth Centre in diverse and more deprived communities to increase the diversity of birthing people and families who use the centre.

Rights and Equality
The staff we spoke with were aware of the Equality Act (2010) and the need to make reasonable adjustments, so that everyone, including individuals with protected characteristics could access and use the service.

We were told that pregnant people can access pregnancy related information via QR codes which are provided by their community midwife. It was explained to us that staff confirm with the pregnant person that they have access to the internet. If this is not achievable, hard copies of the information is provided. Although there is a standardised approach with QR codes, community staff informed us that they give out leaflets on an individual basis. Whilst this is beneficial for some, it may cause inequity as it is based on the initiative of the community midwife. **The health board should consider how they ensure that all pregnant people have equitable access to pregnancy information so that everyone is treated fairly.** It was explained to us that postnatal leaflets are provided which are personalised to the individual woman's circumstances.

The health board have an equality and diversity policy in place, which is accessible to staff via Wisdom. Staff mandatory training in equality and diversity is in place and staff discussions highlighted to us that a person-centred approach to care is present.

Staff told us about arrangements to enable patients from different faiths to access the multi-purpose rooms for quiet reflection /prayer as required.

The Birth Centre is located on the first floor of the hospital with access available via a lift. All corridors leading to, and within the Birth Centre were wide, clear and uncluttered.

Delivery of Safe and Effective Care

Safe

Risk management

We reviewed a report that had been approved by the Board ahead of the reinstatement of services at the Birth Centre. The comprehensive paper provided assurance around safe reinstatement of community services and enabled controllable risks to be identified and mitigated in readiness for the re-introduction of community intrapartum care pathways on 16th September 2024.

Effective systems and policies were seen and described to us by staff for the management of medical emergencies. Staff were aware of health and safety policies and told us they were encouraged to report any safety issues.

Clear and well communicated processes and criteria was in place to mitigate risk and ensure that women who wish to birth at the centre fall within the strict criteria and guidelines.

We were told that transport and transfer of care were included on the health board risk register which was monitored and acted upon when required.

Staff were trained and could describe to us the birthing pool evacuation process and equipment used to ensure the safety of patients when using the pool. Emergency evacuation equipment was seen within the birth pool rooms, which could be used in the event of complications during a water birth. We were also assured that all staff had received training in their appropriate use in the case of emergency.

Given the nature of the small service provided within the Birth Centre, we saw effective constant communication between staff. This ensured that staff are kept aware of ongoing and emerging risks by senior managers, so that any potential risks are minimised.

We found the unit to be uncluttered, clean, tidy and free from hazards. All areas within the unit were well-maintained. There were appropriate processes and audits in place within the unit to manage risk, health and safety and infection control.

Infection, prevention and control (IPC) and decontamination

All areas of the Birth Centre were visibly clean, tidy and free from clutter. Staff told us of their awareness of the infection control policies and the standards they should adhere to. We viewed data which demonstrated regular IPC audits being undertaken with high compliance rates.

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

Safeguarding of children and adults

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be at risk. Safeguarding training was mandatory, for all staff and we reviewed very high levels of compliance.

Birth Centre staff had access to the health board safeguarding procedures via Wisdom. Staff we spoke to were confident in the procedures they would follow in the event of a safeguarding concern.

We considered the unit environment and found sufficient security measures in place to ensure that babies were safe and secure in the unit. Access to the Birth Centre was restricted by locked doors, which were only accessible with a staff pass or by a member of staff approving entrance. Cot mattresses are alarmed, and there is CCTV monitoring located by the midwife coordinators desk within the unit.

A baby abduction drill had not taken place within the five months of the reopening of the Birth Centre. We discussed this with senior managers who confirmed that a drill was planned in due course.

The health board must conduct a baby abduction drill at the Birth Centre as soon as possible. Any associated learning from the drill should be shared with staff members.

Management of medical devices and equipment

Through observations and staff discussions, we saw that the Birth Centre had appropriate equipment and medical devices to meet the needs of women and birthing people.

Documentation reviewed confirmed that regular checks were completed on equipment to ensure it was suitable for use. We found that the emergency trolley, for use in a patient emergency, was well organised and contained all the appropriate equipment. Daily maintenance checks were taking place on this equipment. We saw that standardised kits were contained within each birthing room. This ensured consistency for staff in accessing equipment when required.

Medicines management

We found that there were suitable arrangements for the safe and secure storage and administration of controlled drugs. Keys to emergency drug cabinets were colour coded for clarity and swift access in the event of an emergency. **We consider this to be notable practice.**

We saw evidence of daily temperature checks of the medication fridge to monitor that medication was stored at the advised temperature of the manufacturer.

Effective

Effective care

The health board had a Maternity and Obstetric Dashboard. At the time of our inspection, a maternity dashboard, specific to the birth centre service, had been developed and was at the final stages of refinement. The dashboard provided an opportunity to benchmark services against similar services across Wales. We were assured that there was a good level of oversight of clinical activities and patient outcomes.

The Birth Centre use the Midwifery Unit Standards self-assessment which provides a structured framework to support the self-assessment and improvement of midwifery units. We reviewed the Birth Centre self-assessment document and noted that work to complete the standards was ongoing. **We advise that the health board should continue to complete the necessary action to work towards achieving the Midwifery Unit Standards.**

Nutrition and hydration

During our inspection we did not observe the serving of food. Water and tea and coffee making facilities were available within in all rooms at the Birth Centre. Staff told us that hot food was available via hospital facilities and cold food was readily available when required.

Patient records

We reviewed a total of six sets of clinical records. Overall, we found the standard of record keeping was good and promoted appropriate patient choice. Records were clear, legible and well organised.

Efficient

Efficient

It was explained to us that there had been the recent implementation of an E-community digital workbook. All home visits and clinic appointments are logged onto the system. **We consider this to be notable practice** that aligns with the lone worker policy as the community midwife needs to log into the call and back out of the call when they have completed the visit, which enables them to be tracked for safety purposes. The system will also assist with sharing of the case load and to ensure that no calls are missed when there is a period of absence or sickness from a team member. Staff we spoke to had welcomed the introduction of the new system.

Quality of Management and Leadership

Leadership

Governance and leadership

A management structure was in place with clear lines of reporting and accountability. Permanent posts were in place representing a significant improvement in staffing levels compared to our previous Swansea Bay maternity inspections. We met with enthusiastic leaders responsible for the Birth Centre that shared a vision for women and families to experience the best possible midwifery led care in a homely environment. Leaders and staff that we spoke with told us of a positive change in culture within the health board's maternity service with the re-instatement of the Birth Centre.

It was positive to note that a significant focus of the gateway document developed to enable the safe re-opening of the centre was around staffing and competency. Through management and staff discussions, it was clear that midwifery management support for the re-opening of the Birth Centre was significant and positive. This was reflected within the cohesive and supportive culture within the unit.

The permanent appointment of a Director of Midwifery has given maternity services within the health board a clear voice at board level, allowing the Board to gain a better understanding of these services.

We spoke to the Consultant Midwife, who is based at and oversees the Birth Centre. They were available for staff to seek advice from and were actively leading the development and implementation of new policies and practices within the maternity service. Other senior managers are regularly based at the unit, some splitting their time with maternity services at Singleton Hospital. We noted leadership by example with senior managers wearing midwife uniforms and working bank shifts if required to support the service.

We were told of a daily safe staffing safety huddle taking place Monday to Friday at 9.30am. This is attended via Teams by both Birth Centre and Singleton maternity senior managers and acuity is reviewed against the available workforce. Documentation reviewed noted that the acuity systems use a RAG rating to establish acuity to safe staffing levels. The huddle involves a retrospective review of the previous 24 hours' acuity, staffing levels and impact. It also requires forward planning for the following three days. This enabled constant scrutiny of the establishment. **We saw this as noteworthy practice.**

Staff reported that they were encouraged to escalate if there were capacity issues. Staff were familiar with the escalation policy and where it was located. They described to us the processes contained within the policy to always maintain a safe service if the unit was at, or nearing capacity. We also reviewed a comprehensive flowchart to guide staff during the escalation process. Staff told us that escalation was a process that they were happy to do if needed, and if they had significant concerns. This indicated that staff felt psychologically safe to challenge leaders appropriately and demonstrated a supportive and positive work environment. In addition, senior managers told us that Café conversations took place as a less formal method of engagement with staff, to encourage and enable staff to get their voices heard.

We reviewed the midwifery and medical clinical policies and guidelines for staff available on Wisdom. We identified that some of the printed policies within the Birth Centre were older versions of those available on Wisdom. **The health board should audit, update and share guidelines and policies related to maternity care.**

The health board follow the Chief Nursing Office model for Clinical supervision of midwives and currently have one Clinical Supervisor for Midwives in post. We recognise the good work that is completed; however, staff told us that maternity service would benefit from additional support, health board wide, to ensure the support for the practice of each midwife, including their development needs. **The health board should review the capacity of the Clinical Supervisor for Midwives and consider whether additional support is required.**

At the time of our inspection, we were told there had been a total of 62 births since the Birth Centre re-opened. Whilst there had been capacity to increase birth numbers, this period had been an opportunity to test all of the processes in place. The service now needs to be further embedded into the maternity services structure within the health board to ensure that all staff are confident to promote and refer women to the birth centre service to increase usage. **The health board should continue to share the evidence related to care delivered in the Birth Centre with wider colleagues to encourage appropriate referral and choice for women. This would ensure that all women who are eligible to birth at the Birth Centre are aware of their choices, with a view to increase birth numbers at the centre.** It was positive to note that as a result of the re-opening of the Birth Centre, the number of births in the main obstetric unit have reduced.

Staff felt confident that they can raise concerns and spoke about a positive culture around Datix reporting and learning from incidents. Senior leaders explained to us the process for recording, investigating and learning from incidents. Any learning from incidents is fed back in a prompt and positive way to all staff. Any themes or trends would be identified as part of the process. Examples were shared with us of

two red calls placed to WAST where there had been a delay in transfer to the obstetric unit. There had been no adverse outcomes; however, it is positive to note that these incidents were being taken to the Quality and Safety Committee meeting.

We were told of positive practice with examples of collaboration with other local health boards such as the neighbouring Hywel Dda University Health Board on improvement projects such as learning from incidents.

Workforce

Skilled and enabled workforce

The unit provides a supportive 24/7 model which gives all community midwives working in the environment access to senior midwifery support. A shift allocated band 7 Community Team Manager holds responsibility for the co-ordination, monitoring and appropriate escalation of these services. There is an on-call community midwife who is called into the centre when required to support a birth and provide safe levels of care for women. Community services are staffed in line with birthrate plus ratios.

Managers were visible on unit and comments say that they were approachable, friendly, kind and supportive. We saw well-functioning teams in place and given that the service has recently re-opened after a long closure, there is an acceptance that processes may need change on the back of staff or patient feedback and leaders are not afraid to propose changes. During our inspection, we witnessed good positive working relationships and high morale amongst staff. Staff told us they felt nurtured by the managers and that they had a voice and felt heard. Good working relationships were also reported by staff between midwives at the Birth Centre and the obstetric unit when liaising on transfers of care.

We reviewed rotas, and senior managers confirmed that the unit was compliant with Birth Rate Plus.

We noted that vacancy and sickness rates within the Birth Centre are low. Staffing levels are well managed and there is minimal reliance on bank staff, with only one bank midwife used to provide cover when necessary.

We reviewed processes for monitoring staff attendance and compliance with mandatory training. Overall mandatory training rates at the time of the inspection were at 94%. Community Practical Obstetric Multi-Professional Training (PROMPT) compliance at the time of inspection was at 95%. Infant fetal surveillance training compliance was at 95%, Gap Grow training was at 89% and BFI breast feeding training was at 95%. The good compliance rates indicated that the systems and processes in place for training staff in these mandatory areas are effective and

that women and families using the Birth Centre are being treated by well trained staff.

The high level of training compliance and low vacancy and sickness rates supports the provision of a stable, skilled workforce which meets the needs of women and babies.

Rates of completion of the Performance Appraisal and Development Review (PADR) for midwifery staff over the last year were positive with a high compliance rate of 85%.

We also reviewed a Community Midwife Induction Program document which provided a clear guide for newly appointed Community midwives to support their transition to working in the community environment.

Culture

People engagement, feedback and learning

We reviewed the range of ways in which the health board encourage women to feedback on their experiences. We noted that there were many opportunities for women to feed back on their experiences at different points in their maternity journey. The recruitment of a Patient Experience Midwife and the implementation of a core questionnaire to better understand women's pregnancy journey will provide a broader view of people's views and experiences to shape and improve the services and culture.

We found a positive learning culture within the Birth Centre. Learning opportunities are shared health board wide with the Clinical Supervisor of Midwives working collaboratively alongside colleagues across health boards in Wales. We saw evidence to reflect that the learning culture had much improved in since previous HIW inspections of maternity services within the health board area.

Staff told us that patient feedback was generally fed back to staff. We were told of a "you said, we did" process to gather feedback and implement change.

There was a formal process in place for managing complaints, and this aligned to the NHS Wales Putting Things Right (PTR) process. We were told that there were no complaints currently reported to the Birth Centre.

Information

Information governance and digital technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018 within the unit. On the first day of our inspection, we noted that a door to a room along a corridor where the public could access within the Birth Centre containing patient records was open. We raised this with staff and for the remainder of the inspection the records were securely stored to ensure that patient identifiable information was kept secure.

All staff members had access to the secure IT system. We were told that all guidelines can be accessed on a health board wide database that all staff can use.

Learning, improvement and research

Quality improvement activities

We saw evidence of participation in a range of appropriate research programmes. One example shared was the perineal initiative which has been introduced and is being monitored within the Birth Centre.

Whole-systems approach

Partnership working and development

Good working partnerships were reported with WAST. We were told that whilst their working relationship was positive and constructive, challenges remained with capacity and pressures on the provision of WAST vehicles. We were told that discussions are ongoing between the health board and WAST to negotiate an agreement for a WAST vehicle to be readily available for transfers of care.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
Information Governance On the first day of our inspection, we noted that a door to a room along a corridor where the public could access within the Birth Centre containing patient records was open	There was a risk that patient identifiable information could be accessed	We raised this with staff during the morning of Day 2 of our inspection	For the remainder of the inspection the records were securely stored to ensure that patient identifiable information was kept secure

Appendix B - Immediate improvement plan

Service: Neath Port Talbot Birth Centre

Date of inspection: 4, 5 & 6 February 2025

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	There were NO immediate assurance issues					
2.						
3.						
4.						

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:

Appendix C - Improvement plan

Service: Neath Port Talbot Birth Centre

Date of inspection: 4, 5 & 6 February 2025

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

	Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
1.	**Health promotion** There was a lack of information on healthy eating, physical activity and information for carers within the Birth Centre	The health board should ensure that healthy lifestyle information is available to help support women and their baby while they are pregnant	Create a public health board to include information on healthy eating, physical activity and information for carers within the Birth Centre	Head of Midwifery	31/05/2025
2.	**Equitable** We reviewed signage for people arriving at the Birth Centre and observed there	The health board should consider improving the hospital signage to the Birth Centre to help direct women and their	The Health Board will work with the MVP and consider compiling maps of maternity	Head of Midwifery	31/05/2025

	was only limited signage on display which was too small to be easily noticed	birthing partners to improve their overall experience	services locations across Health Board, including Neath Port Talbot for women and families to be fully informed of our locations and how to find us Implement any agreed solutions following development and sign off and internal governance approval processes	 Head of Midwifery Consultant Midwife	 30/09/2025
3.	**Equitable** We found there were inconsistencies in the provision of how pregnant people can access pregnancy related	The health board should consider how they ensure that all pregnant people have equitable access to pregnancy information so that everyone is treated fairly	The Health Board will ensure a link is added to the Swansea Bay webpage so women and families can access the online	Head of Midwifery	30/06/2025

	information. Although there is a standardised approach with QR codes, community staff informed us that they give out leaflets on an individual basis to those who are unable to access the internet. Whilst this is beneficial for some, it may cause inequity as it is based on the initiative of the community midwife		version of the booklet. However, to ensure access is available to those without internet, we will develop a booking pack that will ensure all community midwives have access to the appropriate information to share with patients. This will be shared with team leaders		
4.	**Baby Safety** We noted that a baby abduction drill had not taken place within the five months of the reopening of the Birth Centre	The health board must conduct a baby abduction drill at the Birth Centre as soon as possible. Any associated learning from the drill should be shared with staff members	A baby abduction drill at the Birth centre was undertaken on 12/3/25. The debrief following the drill showed effective implementation of the baby	Deputy Head of Midwifery/Matron Community services	Completed 12/03/2025

			abduction drill and the safe systems for managing this went without incident		
5.	**Effective care** We reviewed the Birth Centre Midwifery Unit Standards self-assessment document and noted that work to complete the standards was ongoing	The health board should continue to complete the necessary action to work towards achieving the Midwifery Unit Standards	The Health Board attended a Workshop on 31.03.2025 for the implementation of the MUSA standards – the Health Board will be working through a community of practice along with all Health Boards in Wales to deliver the standards as stipulated by the Swansea Bay self-assessment action plan	Consultant Midwife Head of Midwifery	30/09/2025

			The Maternity and Neonatal Network have designed 5 Safety Huddles across Wales, the last being in September 2025, in which each Health Board will attend share learning and good practice and will monitor progress against the MUSA standards. The action plan will be monitored via the service bronze, silver and gold command for onward reporting and escalation to the Quality and Safety Committee		

			and Management Board		
6.	**Policies and Guidelines** Some policies and guidelines relevant to maternity care were out of date or in need of review	The health board should audit, update and share guidelines and policies related to maternity care	The Service Guideline Committee will provide evidence of progress against the policy and guidance update compliance which will be monitored via the bronze, silver and gold command structure for reporting, in addition to the Divisional Quality, Safety & Risk meeting	Head of Midwifery	31/05/2025
			A spot check audit will be undertaken to ensure that all printed policies	Community Matron	30/04/2025

			align with the current electronic versions		
7.	**Governance and Leadership** We recognise the good work that is completed by the Clinical Supervisor for Midwives; however, staff told us that maternity service would benefit from additional support, health board wide, to ensure the support for the practice of each midwife, including their development needs	The health board should review the capacity of the Clinical Supervisor for Midwives and consider whether additional support is required	The service has reviewed current capacity of the Clinical Supervisor for Midwives and is making plans to increase support by a further 0.8 whole time equivalent staff. This will be done on an interim arrangement while we work through a more substantive solution.	Head of Midwifery	30/06/2025
8.	**Awareness of service** The service needs to be further embedded into the	The health board should continue to share the evidence related to care delivered in the Birth	NPT Birth Centre has held an open day, inviting pregnant women and their families	Head of Midwifery Consultant Midwife	31/03/2025 Complete

maternity services structure within the health board to ensure that all staff are confident to promote and refer women to the birth centre service to increase usage	Centre with wider colleagues to encourage appropriate referral and choice for women	and anyone within our maternity community on social media. Additionally, a video has been produced and shared via our social media platforms to showcase the birth environment and encourage local awareness of the service		
		A 6-month review from recommencing services at the Neath and Port Talbot Birth Centre will be compiled to evidence the impact of re-	Head of Midwifery Consultant Midwife	31/05/2025

		opening the community birth pathways This will be presented at the Divisional Quality, Safety & Risk meeting initially for sharing with the wider Maternity Teams at Swansea Bay. It will subsequently be reported through health board governance assurance meetings	 Consultant Midwife	 30/05/2025 (Divisional QSR meeting)

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): Kathy Greaves

Job role: Clinical Director of Midwifery

Date:	**01/04/2025**
Name (print):	**Sharron Price**
Job role:	**NPTS Service Group Nurse Director**
Date:	**01/04/2025**