Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Hospital Inspection Report (Unannounced)

## Maternity Services, Glangwili Hospital, Hywel Dda 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 NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at the Maternity Services, Glangwili Hospital, Hywel Dda University Health Board on 12, 13 and 14 May 2025. The following hospital wards were reviewed during this inspection:

- Antenatal and postnatal ward
- Labour ward
- Midwifery led unit
- Triage and day assessment unit.

Our team, for the inspection comprised of two HIW senior healthcare inspectors, three clinical peer reviewers, and one patient experience reviewer.

During the inspection we invited service users or their partners to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 6 questionnaires were completed by service users or their partners and 65 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

# 2. Summary of inspection

## Quality of Patient Experience

Overall summary:

We found a dedicated staff team that were committed to providing a high standard of care to service users. We witnessed staff interact with service users and their partners respectfully and saw evidence of care being delivered in a calm, clean, tidy and welcoming environment. During our inspection, we spoke to several service users who praised the kindness and professionalism of staff and the quality of support received. The service demonstrated a strong commitment to person-centred care, with bilingual health promotion materials, including breastfeeding support, and a clear emphasis on dignity and privacy.

We observed that staff were attentive and responded promptly to service users' needs. The service also demonstrated a proactive approach to equity and inclusion, with translation services, cultural sensitivity, and a growing emphasis on diversity and equality training. Initiatives such as the maternity passport for neurodiverse individuals and outreach to marginalised communities were noted as good practice. Staff engagement in care planning and the presence of a patient experience midwife further supported the delivery of individualised care.

This is what we recommend the service can improve:

- Encourage staff to increase their confidence in using the Welsh language
- Ensure that Welsh speaking staff are identifiable to service users
- Progress the implementation of a bereavement care pathway aligned with national standards.

This is what the service did well:

- Service users and families told us that they felt well cared for
- Service users emphasised the importance of having opportunities to attend clinics at hospital locations local to their home
- Demonstrated strong commitment to equality, diversity, and inclusion through training and leadership.

## Delivery of Safe and Effective Care

Overall summary:

Arrangements were in place to provide service users with safe and effective care. There were established processes and audits in place to manage risk, health and safety and infection control. Risk management was underpinned by regular audits, daily care planning, and multidisciplinary team (MDT) reviews of incidents with processes in place to ensure that information and learning was shared across the service. While we observed robust practices, we identified areas where national incident reporting and handover procedures could be strengthened.

The introduction of the Birmingham Symptom-specific Obstetric Triage System (BSOTS) was noted as a positive development, though further refinement of audit processes would enhance its effectiveness. Overall, staff demonstrated a strong commitment to patient safety, and audit evidence reflected high compliance across key areas of care.

This is what we recommend the service can improve:

- Handovers should be conducted using the Situation, Background, Assessment, Recommendation (SBAR) format to ensure risk factors regarding service users' history and clinical risk are fully understood
- Early reporting of national incidents in line with the Welsh Government National Incident Reporting Policy
- Improve the Birmingham Symptom Specific Obstetric Triage System (BSOTS) audit process to reflect an analysis and learning outcomes process
- Improvement to staff mandatory safeguarding training compliance.

This is what the service did well:

- Midwifery record keeping
- Positive practice observed throughout one theatre session
- Robust processes and effective multidisciplinary team (MDT) working in reviewing of incident reporting and significant events.

## Quality of Management and Leadership

Overall summary:

A relatively new management structure was in place and clear lines of reporting and accountability were described. We saw that multidisciplinary working appeared effective throughout the unit. There was dedicated, passionate, supportive and visible leadership displayed by the senior and middle management team. Staff we spoke with during our inspection expressed to us that they were happy and enjoyed their jobs.

Staff feedback was overwhelmingly positive, with the majority expressing satisfaction with the quality of care they provided and the support they received.

Staff felt confident raising concerns and described a positive culture around incident reporting and learning. The service had recently received national recognition for its culture and performance, and staff described a strong sense of pride and support in their roles.

This is what we recommend the service can improve:

- Ensure that staff can access up-to-date guidelines and policies on the Wales Information System for the Dissemination of Obstetric, Gynaecology & Midwifery Material (WISDOM)
- Compliance with mandatory training.

This is what the service did well:

- Fostered a positive and psychologically safe working culture, with strong staff engagement
- Regular meetings to improve services and strengthen governance arrangements
- A learning culture is embedded throughout the service
- Staffing levels appeared well managed within the service
- Doctors said they felt well supported by their consultant body.

# 3. What we found

# Quality of Patient Experience

## Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from service users and families who had used this service. A total of six were completed.

Patient comments included:

> *"Staff were wonderful, all levels of staff, ward was clean and food was lovely."*
>
> *"We have been very happy with everything-and are very grateful."*

In addition to the comments received from the completed surveys, the inspection team met with service users and their families in the unit at the time of inspection. All told us that they were happy and were complimentary of the level of care received.

## Person-centred

**Health promotion**
We saw bilingual health promotion information displayed throughout the unit, to inform service users about how they can help their health and well-being. This included information on smoking cessation, United Nations International Children's Emergency Fund (UNICEF), baby friendly initiatives and breastfeeding support. Service users we spoke to during our inspection were positive of the support received from breastfeeding specialists, as well as for those who were unable to, or choose not to breast-feed their babies.

Service users and their partners told us they had been provided with health promotion leaflets and booklets at various stages of their pregnancy. The use of quick response (QR) code links ensured that information provided included current and up to date advice and guidance. We reviewed appropriate online information for service users from Hywel Dda University Health Board, this included pregnancy and health promotion information. The online information was available in a range of different languages.

The hospital was a designated no smoking zone, which extended to the use of vapour/e-cigarettes. We saw appropriate information promoting smoking cessation throughout the unit.

**Dignified and respectful care**
All service users and families we spoke with during the inspection told us that staff treated them with dignity, respect, compassion and kindness.

We heard staff being polite, helpful and demonstrate discretion when engaging in sensitive discussions to ensure they could not be overheard. 98% of respondents to the staff survey said that service users' privacy and dignity was maintained. Curtains were drawn around beds within the bays to respect the privacy of service users who had recently given birth.

All birthing rooms and some of the postnatal rooms had en-suite facilities which helped promote patient comfort and dignity during their stay. Where en-suites facilities were not available, shared toilet facilities were available nearby.

Ward environments provided plentiful side rooms where private care or conversations could be facilitated. Separate toilet facilities were available for birth partners and families.

A bereavement room was available on the labour ward for use in the event of an intrapartum death or a stillbirth. The room was appropriately located away from the birthing rooms to better support patient privacy and dignity at a very difficult time. During our inspection, the bereavement room was occupied. Discreet notices had been placed at the reception desk and doors leading to the labour ward to make staff and service users aware of the need for sensitivity. Bereavement midwives worked across the health board to offer support and advice to service users and their partners. We were told by a bereavement midwife that the service was looking to introduce a bereavement pathway in line with the National Bereavement Care Pathway for Pregnancy and Baby Loss. This would improve the quality and consistency of bereavement care received by service users after pregnancy or baby loss.

The hospital also provided a chaplaincy service and there was a multi-faith room for the use of service users and their families.

**Individualised care**
All service users we spoke with told us that their individual birth choices were discussed and proceeded with in accordance with their preferences. Almost all staff who responded to our staff survey said that service users were informed and

involved in decisions about their care. Staff were observed actively engaging with service users in their care, whose wishes were considered and implemented.

A review of patient records confirmed that discussions around labour, birth, pain relief and feeding choices were documented.

A patient experience midwife was in post to coordinate and ensure the patient voice was heard and represented in decision making. Senior managers told us that a Birth Reflections service was available to any service user and their partner who had given birth in the health board area and offered the opportunity to share and reflect on their experiences of maternity services.

During discussions with the inspection team, service users emphasised the importance of having opportunities to attend antenatal and postnatal clinics at hospital locations local to their home. This provided them with the convenience of avoiding excessive travel and time to attend their appointments. **The inspection team noted this as good practice.**

Senior managers told us of the provision of a dedicated public health midwife to work with outreach teams to encourage engagement with marginalised, diverse communities. A maternity passport had been developed for neurodiverse service users, or those with communication challenges. This ensured that appropriate support was provided for appointments and hospital attendance.

The inspection team noted that every birthing room within the labour ward had a board noting the service user's full name. The board also noted their preferred name to be called. This provided comfort and reassurance to the service user that staff respected their identity.

The triage/day assessment area had facilities to perform ultrasound scans. Scans were carried out by a midwife sonographer who had the ability to scan 15 service users a day. We were told of plans to further develop this service.

## Timely

### Timely care

Service users we spoke to said that staff would attend to their needs in a timely manner, and support was always available. 59 out of 65 of respondents to our staff survey said they were able to meet all the conflicting demands on their time at work.

During our inspection, we witnessed staff on the postnatal ward responding promptly to service users who used their call bells for assistance.

Maternity Early Warning Scores (MEWS) were used throughout the service to highlight when additional care was needed to protect the health of the expectant mother and baby. We noted a sepsis screening tool was available in the sample of patient care records we reviewed which helped to identify patients who may become unwell or develop sepsis. We noted the actions required for a patient with sepsis were displayed in the treatment rooms.

Some staff members that we spoke with confirmed that there are occasional issues with peaks in acuity. As the unit was small, these peaks can have a higher impact on workloads at that time. Staff explained to us the escalation policy and the importance of using it if they had any concerns, or if they were nearing capacity in any area.

## Equitable

**Communication and language**
We noted many staff spoke Welsh and we heard Welsh spoken throughout the inspection. Service users told us that they were grateful they could communicate through the medium of Welsh which was their first language. Whilst this was positive, we identified that not all Welsh speaking staff were identifiable by a Welsh speaker logo on their uniform or lanyard. Some staff we spoke to said they lacked the confidence to speak Welsh. The majority of Welsh speaking staff who responded to the staff survey stated that they only sometimes or never wear the 'Iaith Gwaith' badge or lanyard.

**The health board should consider how to encourage staff to increase their confidence in using the Welsh language and ensure that all Welsh speaking staff are easily identifiable to service users.**

**Rights and Equality**
Staff members told us that they used translation services for service users and families who were not fluent in English or Welsh. Staff were aware of how to access the language line facility and stated they would use face to face interpreters for planned appointments where available.

A review of service users records confirmed that their language choice had been discussed and recorded. Action had been taken to address any language needs where required. We also saw evidence that service users' cultural needs had been respected in the care provided.

We saw evidence of good practice, with the partners of service users enabled to stay overnight. This had been introduced following feedback from service users. A

protocol was in place for partners to sign a register to ensure that staff were aware of who was present overnight. Reclining chairs had recently been purchased to ensure their stay was as comfortable as possible.

Senior managers told us of ways they ensured that diversity and inclusion was embedded into the service. Examples were given of how this had been achieved and the positive impact on service users. We were told that a locum consultant from within the service group was leading on Diversity and Equality training for staff. In addition to the mandatory training, 24 members of staff had started the equality diversity and inclusion (EDI) training with Diverse Cymru which examined how to improve their diversity practice. Staff were also provided with additional EDI training and study days to educate participants about the importance of diversity. We were told that the locum consultant had been nominated for many awards for their contribution to EDI within the service. **We noted the EDI training provision as noteworthy practice.**

Staff members commented:

> *"Equality, diversity and inclusion are themes that are often explored in staff training and reflections. One of our wonderful Consultant Obstetricians Dr [redacted] has done lots of meaningful work surrounding EDI which has been a huge benefit to staff."*

> *"There's been some excellent work done in house to offer additional training on equality and diversity."*

All the service users who answered the questionnaire, and those that we spoke with told us that they had not faced discrimination when accessing or using this health service on grounds of any protected characteristics under the Equality Act (2010). Staff we spoke with provided examples where reasonable adjustments were in place, or made, so that everyone, including individuals with protected characteristics, could access and use the service.

Discussions with senior managers described the services' vision for the future in creating a more diverse workforce. Plans to recruit internationally were currently in their infancy.

# Delivery of Safe and Effective Care

## Safe

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

Service user records we reviewed were of a high standard and confirmed daily care planning promoted patient safety.

We attended a risk management meeting and noted robust processes and effective multidisciplinary team (MDT) working in contributing to the review of incident reporting and significant events. **The inspection team considered this to be noteworthy practice.**

We noted that some cases discussed at the risk management meeting had not been reported as national incidents, in line with Welsh Government National Incident Reporting Policy. Discussions with senior managers advised that their process was to commence an investigation in the first instance to determine whether the incident was reportable. The policy states that it will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date.

**The health board must implement the early reporting of national incidents in line with the Welsh Government National Incident Reporting Policy, and consider downgrading later, where appropriate.**

We saw that handover meetings took place twice daily, at shift change over, with the intention of maintaining continuity of care. Whilst we noted positive practice in the thoroughness of the handover in the triage and day assessment area, we noted that the standardised SBAR was not utilised during the verbal handover. We reviewed the records for one service user. We noted that not all the risk factors regarding their history and clinical risk had been fully understood and handed over verbally by those providing care or recorded on the patient information handover board. Following the handover, we were assured the service user had received an appropriate obstetric review.

**The health board must ensure that all handovers are conducted using the SBAR format, and the service user's history and clinical risk is recorded on the patient information board and documented in the appropriate area within the clinical notes.**

Senior managers told us of the implementation of the Birmingham Symptom-specific Obstetric Triage System (BSOTS) as a standardised formal triage system. The inspection team noted the introduction of BSOTS to be commendable following a maternity service quality improvement project. We saw documentation to support that a recent BSOTS pathway and telephone SBAR audit had been conducted. We considered that further improvements to ensure effective measuring of the triage process could be introduced.

**The health board should consider how to improve the BSOTS audit process to reflect an analysis and learning outcomes process, based on areas of non-compliance.**

Two theatres for obstetric cases were located opposite the labour ward. They were clean, spacious and fit for purpose. A process was in place to ensure that full theatre teams were available for both elective caesarean section births and service users from the labour ward requiring emergency caesarean sections.

We considered how the services' theatre system promoted safe care to service users and noted positive practice throughout the theatre session we observed. We reviewed effective and appropriate checklists, systems and processes in place. We witnessed effective multidisciplinary team working. We saw that service users and their partners were supported and communicated with appropriately in theatre with continuity of care provided throughout their pre-assessment, delivery care and transfer to the enhanced medical unit.

During a handover, we noted an instance within a service user's clinical record where a verbal order for prescription medication had been given by a doctor over the telephone. We spoke to a midwife who confirmed they do accept verbal orders occasionally when it was not possible for a doctor to conduct a face-to-face medical review and knew the clinical history of the service user. We recognise the challenges faced with a small unit, and limited number of doctors available. However, the process of accepting verbal orders seemed to have become an accepted part of the working culture which needed to be explored and reviewed to eliminate any potentially unsafe practice.

**The health board should review the process for verbal orders of prescriptions to eliminate the potential risk of medication errors.**

**Infection, prevention and control and decontamination**
We found the environment in Dinefwr Ward was older and in need of improvement; however, all clinical areas of the maternity services were visibly clean, tidy and free from clutter.

During the inspection, we observed all staff adhering to the standards of being bare below the elbow and saw good hand hygiene techniques. Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. Hand hygiene gels were available throughout the unit; however, on the first night of our inspection, two were empty and needed replacing.

**The health board should ensure that all hand gel containers in ward areas and at the entrances contain hand gel to minimise the risk of infection to service users, visitors and staff.**

During our inspection, we noted that the maternity triage and day assessment unit were located next to each other. Whilst each area had separate bays, both shared the same entrance, exits, corridors and toilet facilities. We advise the health board to consider whether there is a risk that the shared facilities breached infection control protocol.

We saw results from an infection control audit which had recently been carried out by the health board. This audit showed that compliance with infection control was high. The hand hygiene audit carried out in April 2025 showed 100% compliance in all areas.

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

**Safeguarding of children and adults**
During the inspection, throughout the unit, we found comprehensive security measures were in place to ensure that families and babies were safe. Access to all areas was restricted by locked doors, which were accessible with a staff pass or by a member of staff approving entrance through an intercom.

We reviewed evidence of a baby abduction drill that took place in February of this year. There was evidence of feedback and learning shared to ensure the continued security of babies in the department.

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 for staff

was mandatory. However, the compliance rate was low, particularly for level three adult safeguarding training. This was discussed with senior managers who told us they had identified this as an area which required improvement. They shared with us an action plan for improvement which had been developed between the maternity and safeguarding services.

**The health board must provide evidence of an improvement in staff mandatory safeguarding training compliance within eight weeks of the inspection date to confirm that action has been taken to improve compliance.**

All staff that we spoke with were aware of the procedures and processes to follow relating to safeguarding concerns.

**Management of medical devices and equipment**
We reviewed the checks related to medical devices and equipment to ensure that all equipment including resuscitaires and defibrillators were working effectively and safe to use in the event of a medical emergency. Whilst we were satisfied that regular and consistent checks were being carried out, several different systems were in place for documenting the checks which was confusing and inconsistent.

**The health board should ensure that a whole system approach is introduced for the checking and recording of medical devices and equipment to ensure that they are working effectively and safe to use in the event of an emergency.**

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.

It was positive to note that 91% of staff who responded to our staff survey stated that they had adequate materials, supplies and equipment to do their work.

**Medicines management**
We found that there were suitable arrangements for the safe and secure storage and administration of controlled drugs. We saw evidence of temperature checks of the medication fridge to monitor that medication was stored at the advised temperature of the manufacturer. However, there were some dates where these checks had not been completed.

**The health board should ensure that consistent daily checking and recording of fridge temperature checks is introduced to ensure that medication is stored at the required temperature.**

The service has a dedicated pharmacist between the hours of 9am and 5pm, with access to an on-call pharmacist outside of those hours.

**Preventing pressure and tissue damage**
A review of patient records reflected that appropriate checklists were completed, and any ongoing risks of pressure and tissue damage would be monitored. Staff told us that clinical supervisory midwives had promoted the importance of conducting risk assessments which included a 'lunch and learn' session around risk, identification and management. A quality improvement project was currently being undertaken to review the current generalised All Wales risk assessment to adapt it specifically to minimise the risk of maternity service users developing avoidable pressure ulcers.

## Effective

**Effective care**
We found suitable systems in place for capturing and sharing relevant information. During the inspection senior managers were able to assure us that internal audits had taken place and provided the team with evidence of a range of audits and improvements that had taken place. Audit documentation reviewed included monthly hand hygiene audit, mattress audits and spot checks including questions relating to infection control, medicines management, environment of care, patient safety minimising risk. Evidence reflected high compliance in all audits for March and April 2025.

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

**Nutrition and hydration**
We reviewed service user records and saw evidence that fluid balance charts had been completed to a very good standard. This was positive to note as the service was in the process of developing a maternity specific fluid balance chart at the time of our last inspection in November 2022. **We noted this as being noteworthy practice**.

We saw service users being offered hot and cold drinks. All had access to jugs of water within easy reach. We spoke to service users who told us they had access to a choice of what to eat and drink. Hot food was available, along with a supply of food and healthy snacks outside of mealtimes. Staff told us that specific dietary requirements were catered for including allergies, intolerances and religious or cultural requirements.

**Patient records**

We reviewed five patient records. Overall, we found the standard of record keeping was good, with care plans well documented between multidisciplinary teams. We saw that the Modified Early Obstetric Warning Score (MEOWS) was completed consistently in records reviewed.

# Quality of Management and Leadership

## Staff feedback

Responses to our staff survey were positive, with 64 of the 65 staff being satisfied with the quality of care and support they gave to patients. The same number agreed that they would be happy with the standard of care provided by their hospital for themselves or for friends and family, and 60 of the 65 staff expressed that they would recommend their organisation as a place to work.

Staff we spoke to during our inspection expressed to us that they were happy and enjoyed their jobs.

Staff comments included:

> ***"I feel very well supported at Glangwili hospital and feel a valued member of the team. Always opportunities for staff learning, improvement and positive changes in the workplace."***

> ***"I feel very proud to work as part of the maternity team at Hywel Dda. I work on Labour Ward and feel I am part of a fantastic team that provides excellent and safe care to our women and their families. It is a supportive environment overall. There are always lots of teaching and learning opportunities made available. I also feel I could approach every single senior member of staff/manager with any concerns or ideas."***

## Leadership

**Governance and leadership**
A management structure was in place with clear lines of reporting and accountability. This had been recently updated, following the appointment of a Director of Midwifery to the health board. Overall responses to the staff survey relating to the visibility of senior managers was positive. However, 11 of the 65 respondents either disagreed or strongly disagreed with this statement. Additionally, 10 of the 65 staff also disagreed that communication between senior management and staff was effective.

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

> ***"The culture here is amazing. I feel valued in the workplace. All the senior management team are visible and approachable. I haven't experienced that where I worked previously…"***

Whilst numerous positive comments were received from staff regarding senior management, some of the comments reflected a lack of visibility and engagement at directorate level. This should be explored and reflected on by the health board.

We saw the service held several regular meetings to improve services and strengthen governance arrangements. Such meetings included maternity quality and safety group, clinical risk management meetings, monthly audit review meeting, weekly multidisciplinary meetings and weekly Antenatal Cardiotocograpy (CTG) reflections.

Staff told us they felt confident that they could raise concerns and spoke about the positive culture around datix reporting and learning from incidents. All respondents to the staff survey said that their organisation encouraged them to report errors, near misses or incidents. Almost all staff said their organisation treated staff who are involved in an error, near miss or incident fairly. Numerous staff comments in the staff survey supported our findings. They included:

> ***"The way the risk and governance process has changed, has transformed the way we now feel psychologically safe to report incidences & learn from them, and develop new pathways etc to ensure that it doesn't happen in the future."***

During the inspection we were provided with documentation that demonstrated that all maternity policies and guidelines were either in date, or an extension to the expiry date for 6 months had been granted. We reviewed the obstetrics and midwifery and medical clinical policies, procedures and guidelines available on WISDOM which reflected that some policies were out date.

**The health board must ensure that staff can access up-to-date guidelines and policies on WISDOM, including the dates they are due to be reviewed.**

An informative monthly maternity newsletter was produced by the service. Contributions to the newsletter include the maternity experience midwife, clinical risk and governance, ward managers, clinical supervisors for midwives, practice development team and perinatal mental health midwife. All revised, reviewed and new guidelines were highlighted in the maternity monthly newsletter. **We considered the newsletter to be noteworthy practice.**

## Workforce

**Skilled and enabled workforce**

We saw a dedicated, passionate, supportive and visible leadership team at Glangwili, with learning embedded throughout the service. All midwives we spoke with expressed how much they enjoyed working in their role. They told us they felt supported, validated and when they raised concerns, they felt listened to. Staff in junior leadership positions reported they also felt very supported.

The positive feedback from staff at all levels was reflected through achievements by the service in winning numerous awards. Earlier in 2025, the service won three UK Maternity Unit Marvels (MUM) awards relating to culture and teamwork including the UK Workforce award. The health board had also recently been recognised at a national level by the National Institute for Health and Care Excellence (NICE) in attaining the highest level of compliance of timely access to antenatal care in Wales.

We observed ward rounds which were relaxed, in-depth, and included a teaching element. Ward rounds were inclusive of medical and midwifery students into which individual learning goals were incorporated.

Through discussions with senior managers and review of staff rotas and acuity, we saw that staffing levels appeared well managed within the service. This was supported by discussions with ward managers and staff. Staff told us that if there were any shortages of staff cover, senior or specialised midwives would step in to cover when required.

However, some staff comments were not reflective of this. Comments included:

> ***"Staffing is sometimes an issue, often short of midwives on shift and lots of extra shifts available sometimes at short notice which can be daunting coming onto a shift knowing we are short staffed."***
>
> ***"I work on the MLU. Often staff are pulled to other wards and low risk women are then invited to triage to be assessed. This should not be the case."***
>
> ***"There should always be 6 healthcares on each shift, so if we have sickness we are only down to 5, when they cover the shift with 5 healthcares and 1 person phones in sick that leaves only 1 healthcare on each ward, this can be really hard going on the healthcares."***

Senior managers should reflect on these comments and continue to monitor and appropriately manage staffing levels.

The health board should reflect on the comments made by staff about the:

- Lack of visibility and engagement by directorate management
- Shortage of staff on occasion and appropriately manage staffing levels.

The inspection team spoke to doctors who said they felt well supported by their consultant body. The clinical lead described to us the management structure of the unit, with low vacancy and low long term sickness episodes for medical staffing. The inspection team considered the junior staffing model for doctors was appropriate for the service unit. A plan was in place to increase consultant coverage to 60 hours a week through recruitment to serve the needs of the unit. This would lead to an increase in consultant resident time while decreasing the frequency of on-calls.

We reviewed Performance Appraisal and Development Review (PADR) rates for midwifery staff over the last year. These were currently at around 80% with a plan in place to further improve the compliance rate. This would ensure an effectively skilled and enabled workforce, support wellbeing and ensure that performance issues could be addressed and resolved in a timely manner.

Feedback from the staff survey confirmed that 60 of the 65 staff felt they had appropriate training to undertake their role. However, only 11 of 21 Welsh speaking staff agreed that they were given the opportunity to complete their training in Welsh. Whilst some positive comments relating to training were received, other staff comments included:

> ***"We are well supported on shift and if needed on post event reflections. There are often learning opportunities in reflections or courses run but these are in our own time which is difficult to manage."***
>
> ***"Coming into a management role from a non-management band 7 role was challenging. So many different aspects of management that include performance reviews, managing attendance at work etc. Specific pre planned training would have been very helpful."***

During discussions with staff about the enhanced monitoring unit, the inspection team were not assured that all staff had received sufficient training to upskill them into their roles to care for more complex service users.

**The health board should evaluate the skill levels of staff working within the enhanced motoring unit to ensure their knowledge and skills are appropriate for their role in caring for more complex service users.**

We reviewed the data for monitoring staff attendance and compliance with mandatory training. The spreadsheet highlighted that an improvement in compliance is required.

**The health board must ensure that mandatory training compliance is improved.**

## Culture

### People engagement, feedback and learning

Discussions with senior managers emphasised their aim to ensure that a learning culture was embedded throughout the service. An emphasis has been placed on the creation of a culture of psychological safety for their staff. This was supported by discussions with staff during the inspection.

Staff comments included:

> ***"The culture within the maternity unit has become exceptional over recent years with major changes of ethos which have been fully embraced by colleagues. There is a significant emphasis on learning and development over fear and blame which has made me a safer practitioner."***
>
> ***"This is a very supportive environment to work in and I genuinely feel that everyone in the team is valued. The clinical risk team have made huge improvements to staff's psychological safety and are very open and transparent…"***

## Information

### Information governance and digital technology

The inspection team considered the arrangements for patient confidentiality and adherence to information governance and the General Data Protection Regulations (GDPR) 2018 within the unit. We saw evidence of patient information being stored securely throughout our inspection.

We saw documentation which confirmed that monthly audits were undertaken within each ward area to ensure that patient records were stored in a lockable documentation trolley or cupboard.

## Learning, improvement and research

**Quality improvement activities**
Staff were encouraged and supported to become involved in quality improvement projects, to enhance the quality of the service provided, and to aide with staff development. All staff groups spoken to were very receptive to changes, initiatives and quality improvement projects.

We saw evidence of effective outcomes because of previous quality improvement projects undertaken within the service. Senior managers told us of a recently commenced project to support staff who may be impacted by vicarious victim trauma.

# 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**<br><br>There were NO concerns requiring resolution during the inspection | | | |
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# Appendix B – Immediate improvement plan

**Service:** Glangwili Maternity Services

**Date of inspection:** 12, 13 & 14 May 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. | | | | | | |

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:** Cerian Llewellyn

**Name (print):** Cerian Llewellyn

**Job role:** Interim Head of Midwifery

**Date:** 14/07/2025

# Appendix C - Improvement plan

## Service: Glangwili Maternity Services

## Date of inspection: 12, 13 & 14 May 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. | **Equitable**<br>Not all Welsh speaking staff were identifiable by a Welsh speaker logo on their uniform or lanyard. Some staff said they lacked the confidence | The health board should consider how to encourage staff to increase their confidence in using the Welsh language and ensure that all Welsh speaking staff are easily identifiable to service users. | The service will ensure that lanyards are available to all staff to highlight that they are able to communicate in Welsh.<br><br>The Maternity Monthly Newsletter will signpost all staff to Welsh language courses to increase awareness and confidence | Interim Head of Midwifery<br><br>Interim Head of Midwifery | 22nd Aug 2025<br><br>30th November 2025 |

| | | | | | |
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| | to speak Welsh. | | | | |
| 2. | **Safe Care** Some cases discussed at a risk managemen t meeting had not been reported as national incidents, in line with Welsh Government National Incident Reporting Policy. | The health board must implement the early reporting of national incidents in line with the Welsh Government National Incident Reporting Policy, and consider downgrading later, where appropriate. | The service and Health Board can confirm measures are embedded to review and comply with the early reporting of national reportable incidents, in line with the Welsh Government National Reporting Policy. All incidents are and will be considered for reporting during early IMG discussions and if an act or inaction is identified an NRI will be reported at the earliest possible point possible. | Patient Safety and Assurance Manger | Complete |
| 3. | **Safe Care** The standardise d SBAR was not utilised during a | The health board must ensure that all handovers are conducted using the SBAR | The Health Board will ensure a standardised SBAR approach to handover which will be monitored by the senior | Interim Head of Midwifery | 31st August 2025 |

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| | verbal handover meeting. | format, and that service users' history and clinical risk is recorded on the patient information board and documented in the appropriate area within the clinical notes. | clinicians at each handover<br><br>The Maternity Risk and Governance Newsletter to reiterate the importance of ensuring a holistic approach to handovers which is inclusive of relevant history and prudent to ensure efficient, timely and safe handover of care | Interim Head of Midwifery | 30th Sept 2025 |
| 4. | **Safe Care** Effective measuring of the BSOTS triage process could be introduced. | The health board should consider how to improve the BSOTS audit process to reflect an analysis and learning outcomes process, based on areas of non-compliance. | An audit of the BSOTS to be conducted which will include compliance across areas of BSOTS guidance.<br><br>The data from the audit will be utilised to develop a clear and objective action plan for areas of improvement and learning outcomes will be disseminated service and Health Board wide | Interim Head of Midwifery<br><br>Interim Head of Midwifery | 17th Oct 2025<br><br>30th November 2025 |

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| **5.** | **Safe Care**<br>A verbal order for prescription medication had been given by a doctor over the telephone. | The health board should review the process for verbal orders of prescriptions to eliminate the potential risk of medication errors. | Staff to be reminded via the Maternity Monthly Newsletter and during group supervision delivered by the Clinical Supervisors for Midwives that verbal orders prescriptions are permitted only in exceptional circumstances when in the nurses' professional judgment, patient safety or care would otherwise be compromise.<br><br>Posters to be placed in all clinical areas to remind staff of the above.<br><br>An audit of verbal prescriptions to be undertaken to identify areas for improvement | Interim Head of Midwifery<br><br>Interim Head of Midwifery<br><br>Interim Head of Midwifery | 31st October 2025<br><br>31st October 2025<br><br>31st October 2025 |
| **6.** | **Safe Care**<br>Two hand hygiene gels | The health board should ensure that all | In collaboration with Hotel Services all staff to be reminded that in the event | Interim Head of Midwifery | 30th July 25 |

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| | were empty and needed replacing. | hand gel containers in ward areas and at the entrances contain hand gel to minimise the risk of infection to service users, visitors and staff. | that a hand gel is not readily available this should be escalated and replaced without delay | | |
| **7.** | **Safe Care** Compliance rate for safeguarding training was low, particularly for level three adult safeguarding training. | The health board must provide evidence of an improvement in staff mandatory safeguarding training compliance within eight weeks of the inspection date to confirm that action has been taken to | A detailed action plan to be produced and agreed along with senior leaders from the Safeguarding Team to ensure improved compliance with mandatory safeguarding training.<br><br>The Maternity Monthly Newsletter to be updated with all relevant information on accessing safeguarding training. | Interim Head of Midwifery<br><br>Interim Head of Midwifery | 20th Sept 25<br><br>30th Sept 2025 |

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|---|---|---|---|---|---|
| | | improve compliance. | Monitoring of compliance will be reviewed on a monthly basis across the service by the senior midwifery team, this will ensure a consistently increasing trajectory of compliance | Interim Head of Midwifery | 30th Sept 2025 |
| **8.** | **Safe Care** Several different systems were in place for medical devices and equipment checks documenting the checks which was confusing and inconsistent. | The health board should ensure that a whole system approach is introduced for the checking and recording of medical devices and equipment to ensure that they are working effectively and safe to use in the event of an emergency. | During the inspection a mixed method of both paper and digital forms of equipment and medical device was in place, the service to implement a single whole system method of medical device and equipment checks to avoid any future inconsistencies. | Interim Head of Midwifery | 30th Aug 2026 |

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|---|---|---|---|---|---|
| **9.** | **Safe Care** There were some dates where recording of daily fridge temperatur e checks had not been completed. | The health board should ensure that consistent daily checking and recording of fridge temperature checks is introduced to ensure that medication is stored at the required temperature. | Daily fridge check and accurate recording of temperatures to be formally embedded within the daily checks and compliance monitored by the labour ward manager | Interim Head of Midwifery | 22nd Aug 2025 |
| **10.** | **Effective Care** Obstetrics, midwifery and medical clinical policies, procedures and guidelines available on WISDOM reflected | The health board must ensure that staff can access up-to-date guidelines and policies on WISDOM, including the dates they are due to be reviewed. | The Risk and Governance Newsletter will include a reminder to all staff that in the first instance guidelines and policies should be accessed via the Health Board intranet page as there is greater governance around this.<br><br>As WISDOM is an externally support webpage, the maternity service along | Interim Head of Midwifery<br><br>Interim Head of Midwifery | 12th Sept 2025<br><br>30th October 2025 |

| | | | | | |
|---|---|---|---|---|---|
| | that some policies were out date. | | with the central policies team will work with the provider to review and monitor guidelines and ensure that all guidelines are in date | | |
| **11.** | **Effective Care** Comments received in our staff survey and observations during our inspection highlighted areas of training to be considered by the health board. | The health board should reflect on the comments and observations on page 23 of the report, including upskilling midwives working within the enhanced monitoring unit and consider whether further improvements could be made to address these areas. | There is a newly established core team which has been developed to provide holistic care in the enhanced monitoring unit, a training needs analysis to be conducted to identify specific areas for improvement.<br><br>PROMPT 2025/2026 mandatory training programme has been reviewed and updated and will reflect recognition and management of the deteriorating patient to reflect a broader culture of learning | Interim Head of Midwifery<br><br>Interim Head of Midwifery | 30th November 2025<br><br>30th November 2025 |
| **12.** | **Effective Care** | The health board must | The data report of compliance with | Interim Head of Midwifery | 31st October 2025 |

| | | | | | |
|---|---|---|---|---|---|
| | We reviewed the mandatory training spreadsheet and noted that an improvement in compliance is required in all areas. | ensure that mandatory training compliance is improved. | mandatory training to be updated to reflect rolling compliance in line with standards, this will support enhanced monitoring of compliance in real time.<br><br>The service will undertake a scoping exercise of specific areas of mandatory training where improvement is required, a plan to increase compliance to be embedded and reviewed by senior leaders. | / Clinical Lead Obstetrician / Service Delivery Manager for Obstetrics<br><br>Interim Head of Midwifery / Clinical Lead Obstetrician / Service Delivery Manager for Obstetrics | 31st October 2025 |

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 Cerian Llewellyn**

**Name (print): Cerian Llewellyn**

**Job role: Interim Head of Midwifery**

**Date: 14/07/2025 Updated 25/07/2025**