Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Birth Centre, Ysbyty Ystrad Fawr Hospital, Aneurin Bevan 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.

Contents

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 Ysbyty Ystrad Fawr Birth Centre, Aneurin Bevan University Health Board on 18 and 19 June 2025. This is a freestanding midwifery led unit, without on-site medical cover, offering low risk births as well as antenatal and postnatal care. It is located within Ysbyty Ystrad Fawr.

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

During the inspection we invited patients or their carers 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 eight questionnaires were completed by women or their families and eight 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 that women and birthing people received care that was dignified, respectful and tailored to their individual needs. The Birth Centre provided a welcoming and homely environment, with staff demonstrating compassion and professionalism throughout. Health promotion was actively supported, and bilingual resources were available. Individualised care planning was evident, and timely access to care was generally well managed, although improvements are needed in communication around out-of-hours access.

This is what we recommend the service can improve:

- Improve signage consistency across the hospital to ensure clear direction to the Birth Centre
- Review and enhance communication protocols for accessing the Birth Centre out of hours
- Consider the location of the neonatal resuscitaire unit to ensure privacy and dignity are maintained.

This is what the service did well:

- Individualised care was evident, with birth choices supported and documented
- Health promotion activities and bilingual resources were well integrated
- Effective transfer protocols and timely care were in place
- Equality and diversity were actively promoted, with good engagement across communities.

Delivery of Safe and Effective Care

Overall summary:
The Birth Centre demonstrated a strong commitment to safety and clinical effectiveness. Risk management processes were robust, and infection prevention measures were well adhered to. Safeguarding procedures were clear and well understood. Equipment and medicines were appropriately managed, and electronic records supported safe and efficient care delivery.

This is what we recommend the service can improve:

- Continue work towards full implementation of the Midwifery Unit Standards.

- Review security measures in light of increased footfall.

This is what the service did well:

- Risk assessments and care planning were thorough and well documented
- Staff were trained in emergency procedures, including birthing pool evacuation
- Safeguarding compliance was high, and procedures were well understood
- Equipment and medicines were safely stored and regularly checked
- Transfers to obstetric units were timely and well-coordinated.

Quality of Management and Leadership

Overall summary:
Leadership within the Birth Centre was visible, approachable and supportive. Governance structures were in place, and staff felt confident raising concerns. Training compliance was high, and staff morale was positive. Quality improvement and partnership working were evident across the service.

This is what we recommend the service can improve:

- Continue to review and strengthen leadership structures
- Ensure governance capacity is sufficient to support the scale of service delivery.

This is what the service did well:

- Staff felt supported by senior leaders and midwifery managers
- Governance processes were in place to monitor incidents and drive improvement
- Mandatory training and PADR compliance were strong
- Staff engagement and morale were positive, with low sickness and vacancy rates
- Quality improvement and partnership working were actively promoted.

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 used paper and online questionnaires to obtain views and feedback from people who had used this service. A total of eight were completed.

In addition to the comments received from the completed surveys, the inspection team met with women 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 women and families about how they can keep healthy during pregnancy and birth. This included information boards on mental health, active birth and biomechanics as well as information on classes and roadshows promoting healthy pregnancies.

There was information available on smoking cessation, the baby friendly initiative for breastfeeding support, as well as classes that were available to pregnant women to improve pregnancy fitness. Of note there were antenatal yoga classes that were free and very well attended. The “Almost There” clinic was offered to women in the later stages of their pregnancies to discuss concerns and positive actions that could improve health and comfort in later pregnancy.

The electronic maternity records system in use allowed patient health information relating to the stages of pregnancy to be sent out electronically to women at appropriate stages of their pregnancy.

The hospital was a designated no smoking zone, which extended to the use of vapour/e-cigarettes.

Dignified and respectful care
All people that we spoke with during the Birth Centre inspection told us that staff treated them with dignity, respect, compassion and kindness.

We heard staff being polite, helpful and discrete when engaging in sensitive discussions to ensure they could not be overheard. All of respondents to the staff survey said that women's privacy and dignity was maintained.

The Birth Centre offers a welcoming environment with accessible rooms and birthing pools. All birthing rooms had ensuite facilities.

We saw that there was the facility to have some resuscitation equipment in the rooms, but not the resuscitaire The neonatal resuscitaire unit was available and accessible outside of the birth rooms and, should it be needed, the newborn would be taken away from the mother for resuscitation. Whilst the location of the unit was not far, staff informed us that the doors could be left open so that the mother could see the resuscitation and their baby. This may pose some dignity and privacy issues.

The health board should review the location of the neonatal resuscitaire unit to mitigate possible compromised dignity for women should it need to be used.

Individualised care
All people we spoke with told us that their individual birth choices were discussed and proceeded with according to their stated preferences. All staff who responded to our staff survey said that people were informed and involved in decisions about their care.

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.

A review of electronic maternity patient records confirmed that discussions around labour, birth, pain relief and feeding choices were documented. Midwives told us that where possible, women's choices were prioritised and discussions around birthing outside of guidance were held with the Consultant Midwife so that those choosing this are fully informed and where possible a plan can be put in place to minimise risks. Midwives told us that are happy to advocate for women's choices.

Parent education 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.

There were several specialist midwives in post to support families that needed some additional or specialist support. This included the mental health midwife in place who also provided support for women with low to moderate mental health problems. We saw individualised care and additional care pathways and advocacy for women with difficulties in these and other areas.

Timely

Timely care

Women told us that staff were very helpful and would attend to their needs in a timely manner. Staff told us that they would do their best to ensure that all patient needs are met and patient records demonstrated that this took place.

The Birth Centre is staffed during daytime hours by community midwives, where they use the centre as their base. It is not routinely staffed overnight. Staff described arrangements for care out of hours care whereby a community midwife on call would come into the unit to support an out of hours birth should this be required. Whilst some notices were seen describing these arrangements, limited information on this process was found on the health board website. When we spoke with some women, they shared some challenges and confusion around gaining access to the centre whilst waiting for a midwife. Some community midwives confirmed that they had experienced some challenges with their hospital passes out of hours.

The health board must review and improve systems and communication around access to the Birth Centre after hours to ensure that delays to care and confusion are not experienced.

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 Welsh Ambulance Service Trust (WAST) priority systems and undertaken in a timely manner. Discussions with staff also confirmed positive working relationships with obstetric unit staff as well as WAST in consulting and preparing for transfers of care.

An effective 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[1] score, were recorded on the Datix incident reporting system. It was explained that any transfer delay would be reported for lessons learned and/or missed opportunities. Any departmental concerns would be escalated, and any transfer delay will be reported, managed and investigated.

A transfer review meeting takes place every other month to review all transfers and ensure that they were appropriate and timely, with notes available and learning shared.

Midwives we spoke with welcomed the upgrade to electronic maternity patient records across the health board and told us the scheduling of appointments in line with national maternity guidelines was automatic within this system. This had improved efficiency and ensured that appointments were timely.

Maternity Early Warning Scores (MEWS) were used to highlight when a transfer of care to a more appropriate consultant led unit was needed to support the pregnancy and birth. An appropriate sepsis screening tool was used through the electronic patient records system. This helped to identify patients who may become unwell or develop sepsis.

Equitable

Communication and language
There were a range of hospital signs directing people from the hospital entrance / car park to the Birth Centre. We saw that the Birth Centre signs were not consistently worded. Signs for "Maternity", "Birth Centre", "Birthing unit", "Birthing Suite" were all seen in the hospital. The different names could be confusing for those attending the Birth Centre and may lead to delays in accessing care.

The health board must ensure that signs to the Birth Centre are consistent and clear to minimise the risk of people struggling to access the unit in a timely manner and to help improve their overall experience.

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[1] The Apgar score is a test given to newborns soon after birth. This test checks a baby's heart rate, muscle tone, and other signs to see if extra medical care or emergency care is needed.

Welsh language speaking staff within the Birth Centre were identifiable through the “iaith gwaith” logo. Some limited bilingual information was also seen on patient information boards within the antenatal outpatient area 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 an iPad can be used to carry out appointments virtually with an interpreter.

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.

The health board has an equality and diversity policy in place, which was 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.

We were told that information is provided about the Birth Centre is all birthing people who fall within the birthing criteria and guidelines. Staff told us of ways that they engage with diverse communities and more deprived communities to increase awareness of what is available within the Birth Centre and to increase the diversity of birthing people and families who use it. Notable good practice around the use of volunteers to support the work of the Babi [2](Birth and Bump Improvement) group across the health board. We were told that many new volunteers spoke a wide range of languages and were able to provide feedback on services for from their point of view, as well as being able to reach into communities that have previously not engaged with the health board in maternity services.

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.

[2] Babi group is a support group for maternity service users of Aneurin Bevan University Health Board

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.

Clear and well communicated processes and criteria was in place to mitigate risk and ensure that women who wish to birth at the centre either fall within the criteria and guidelines or are offered an appointment with the Consultant Midwife to discuss their case and opens, assessing the risk and mitigating those where possible.

Maternity records we reviewed were completed electronically and of a high standard. Records confirmed care planning that promoted patient safety. Risk assessments were automatically flagged through the system and prompted the midwife to complete these during the initial booking appointment. The records reviewed detailed electronic referrals completed when needed.

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.

Infection, prevention and control and decontamination
We found the Birth Centre to be visibly clean, tidy, free from clutter and furnished to a good standard that allowed for effective cleaning.

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 Birth Centre.

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.

All Birth Centre staff had access to the health board safeguarding procedures, these were available on a shared IT system. Staff we spoke to were confident in the procedures they would follow in the event of a safeguarding concern.

Clear record keeping on safeguarding was supported by electronic records system and compulsory completion of safeguarding information.

We considered the unit environment and found some 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 and exit.

Staff confirmed that babies born in the Birth Centre usually stayed in the unit for a short time, sometimes just for a few hours. At the time of inspection, baby name bands were not routinely used. Staff told us that this was because of the short time in the unit. The lack of baby name bands on all babies born represented a risk to baby safety, especially in of light increased use of the centre as a hub for pregnancy. This issue was addressed during inspection and, with immediate effect, leaders confirmed that all babies born in the Birth Centre would all have a baby name tag regardless of amount of time remaining in the centre. **More information can be found in Appendix A of this report.**

A baby abduction drill had not taken place within the last year at the Birth Centre. We discussed this with senior managers who advised that, due to the low number of births taking place in the centre it was not considered appropriate as with around four births per month, when families remain only for a short period this may not be currently appropriate.

Considering the increased footfall through the Birth Centre, the health board must complete a full review of security measures in place at the Birth Centre whilst birth numbers are low and, when birth numbers increase, an abduction drill should be performed. All learning from a review and subsequent drill must be shared with staff and risks mitigated accordingly.

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 people using the centre

Birth pools were cleaned after every use and a regime was available for staff to follow.

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

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.

Medicines management
We found that there were suitable arrangements for the safe and secure storage and administration of all medication including the secure storage and checking of controlled drugs. Midwives described a stock checking and rotation system was described.

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 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 electronic, clear and included relevant risk assessments including falls risks and safeguarding information.

Efficient

Efficient

We reviewed documentation that showed number of births at the centre had decreased over recent years, staff confirmed that the number of community births had increased, and significant efforts were being made to increase awareness of facilities at the Birth Centre within the community. This was commendable, during the inspection antenatal classes were delivered this included antenatal yoga, parent education as well as several clinics.

Community midwifery teams use the Birth Centre as their base, which helps with daily calls and sharing calls. Community midwives are on call for all home births and births in the Birth Centre across Aneurin Bevan health board. Midwives we spoke with told us that using the Birth Centre as their base worked well.

Quality of Management and Leadership

Leadership

Governance and leadership
A management structure was in place with clear lines of reporting and accountability. Many staff that we spoke with during the inspection said that they felt that they could approach their midwifery managers, and senior leaders were approachable, friendly and kind.

A small senior midwifery management team (in comparison to other health boards) were in place and the health board is responsible for a large number of births, although only a small number of these births take place at this Birth Centre. Senior leaders confirmed that some structural changes were being considered as Aneurin Bevan University Health Board is the only area of Wales without a Director of Midwifery.

The health board should continue to review, engage with, update and communicate any changes in leadership structures to ensure that the health board maternity services are appropriately represented at strategic level and that midwifery staff are supported.

We saw the service held regular meetings to improve services and strengthen governance arrangements. Processes were in place to monitor and act on serious incidents as well as themes from Datix reports. A midwifery governance lead is in post, and we were told that plans were in place to recruit additional posts to governance.

The health board should ensure governance capacity is sufficient to support the service.

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. It was positive to note that leaders from the Birth Centre were actively involved in the action, review and closing of some Datix reports.

We spoke to the Consultant Midwife, clinical supervisors for midwives and specialist midwifery leads. We were told that 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.

Workforce

Skilled and enabled workforce
We met a committed and professional team providing midwifery services to people within the Birth Centre environment as well as caring for women and families in the community. Community midwives use the Birth Centre as a base from which to deliver their work - there are also clinics, antenatal and postnatal courses and health promotion activities delivered within the setting. Midwives that we spoke with told us that the staffing rotas for the Birth Centre worked well.

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.

We reviewed processes for monitoring staff attendance and compliance with mandatory training. Overall mandatory training rates at the time of the inspection were at 84%. 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. All staff confirmed that they had appropriate training for their role.

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. All staff that we spoke with confirmed that they felt that the skill mix within the Birth Centre was appropriate and that the morale was positive with low levels of sickness absence reported.

Some staff told us that they were proud of the training and awareness raising around human rights, kindness and compassion that the unit had undertaken over the last five years. This was seen as notable practice.

Culture

People engagement, feedback and learning
There were opportunities displayed for patients to provide feedback. Posters providing details of how to do this were displayed within the Birth Centre.

There was a formal process in place for managing complaints, and this aligned to the NHS Wales Putting Things Right (PTR) process. We reviewed an appropriate system for monitoring complaints and concerns that would enable leaders to quickly identify and address any trends.

Midwives told us that they had implemented a Greatix initiative. This was put in place to encourage positive feedback to staff that have gone over and above in their work.

The Head of Midwifery confirmed that she has an open-door policy for staff to feedback. Clinical Supervisors For Midwives, Consultant Midwife and other partners and leads were also available to ensure that staff can share any concerns. During the inspection leaders were visible and approachable.

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. The health board does not use paper maternity records. We reviewed electronic patient records on an electronic maternity healthcare system that allows real-time recording of all events wherever they occur: in the hospital, the community, or at home. These online records were securely stored and were easily for staff to access for record keeping, risk assessment, audit and improvements.

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

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.

Leaders confirmed that a health board Wellbeing Strategy for maternity was being developed and that plans were in place for clinical leaders to receive Trauma Informed training which will support clinical debriefs and support wellbeing.

Whole-systems approach

Partnership working and development

We were told of many examples of partnership working both within and outside of the health board staff. Examples include the positive working relationships between community staff and those based in the health board obstetric unit that meant when women needed transfers this could be facilitated safely and quickly.

Staff also reported that good working partnerships were in place with WAST. WAST staff attended the community PROMPT training at the Birth Centre and engaged positively with any reviews related to 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
Some staff told us that not all babies born in the unit have a name band attached	Security risk	Raised with managers on site	Managers addressed this with all staff and changed practice with immediate effect

Appendix B – Immediate improvement plan

Service: Ysbyty Ystrad Fawr Birth Centre

Date of inspection: 18 and 19 June 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
No Immediate Assurance concerns were identified during the inspection					

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: Ysbyty Ystrad Fawr Birth Centre

Date of inspection: 18 and 19 June 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	Standard / Regulation	Service action	Responsible officer	Timescale
1.	There was inconsistent signage regarding maternity across the hospital site that would lead to delays and poor patient experience.	Improve signage consistency across the hospital to ensure clear direction to the Birth Centre.	Quality of Patient Experience	A works and estates request was submitted on 4 August 2025 to install additional signage and provide clearer directions to the Birth Centre. This action will help staff, service users, and visitors navigate more easily, ensuring timely access to the Birth Centre and clinic spaces.	Assistant Service Manager	By 14 October 2025
2.	One patient told us that she had struggled to access the Centre	The health board must review and improve systems and communication	Quality of Patient Experience	Improved signage will be erected to support clear directions to Ante Natal Clinic and Birth Centre.	Assistant Service Manager	By 14 October 2025

	when in labour. Some midwives had also struggled with their passes out of hours.	around access to the Birth Centre after hours to ensure that delays to care and confusion are not experienced.		All staff badges will be checked to ensure appropriate access permissions to the Birth Centre. Any badge access identified will be escalated and rectified with immediate effect. Staff to be reminded to report any badge access problems promptly to management.	Senior Midwifery Manager Community and Antenatal Services	5 August 2025
				When the Midwives are undertaking community PROMPT they will all check their ID badges for access.	Senior Midwifery Manager Community and Antenatal Services	5 August 2025
				Women who are booked for the birth centre will be invited in for a tour to ensure they are familiar with the unit.	Senior Midwifery Manager Community and Antenatal Services	30 September 2025

				A reminder was sent to staff in the alongside birth centre to confirm the location for birth when women seek advice via telephone out of hours. Additionally, staff will continue to be reminded to confirm birth location during out-of-hours calls.	Senior Midwifery Manager Community and Antenatal Services	
3.	The neonatal resuscitaire was not located in birth rooms.	Consider the location of the neonatal resuscitaire unit to ensure privacy and dignity are maintained.	Quality of Patient Experience	The resuscitaire is portable and can be moved into the birth room if the baby requires resuscitation. This would allow immediate support to the baby while maintaining proximity to the mother and uphold dignity and privacy.		

				The service will continue to monitor birth activity levels, and if birth numbers increase a review will be undertaken of the feasibility of an additional resuscitaire to support in room resuscitation.	All birth centre staff	5 August 2025
				Staff will be reminded of the importance of maintaining dignity and privacy during emergency interventions, including appropriate use of doors and screens.	All birth centre staff	12/08/25
4.	Staff had started to work towards the Midwifery Unit Standards	Continue work towards full implementation of the Midwifery Unit Standards.	Delivery of Safe and Effective Care	ABUHB has been chosen to pilot the accreditation for 'Midwifery Unit Self-Assessment' (MUSA).	All staff members / Consultant Midwife / All Senior Midwifery Managers	On-going with quarterly huddles Anticipated completion January 2026

				Staff from alongside and freestanding unit have completed the MUSA self-assessment form. Results were collated and fed back to Health boards.	All staff members / Consultant Midwife / All Senior Midwifery Managers	Complete
				Monthly huddles are being attended by staff to discuss relevant topics e.g. philosophy of care, governance, care outside of recommendations, ethos of care.	All staff members / Consultant Midwife / All Senior Midwifery Managers	Ongoing on a monthly basis
				MUSA newsletter shared with staff regularly. Information sharing around implementation dates and relevant standards.	All staff members / Consultant Midwife / All Senior Midwifery Managers	Complete and ongoing
				MUSA summary shared at Maternity and Neonatal Improvement Assurance Group meeting in February 2025.	Consultant Midwife	Shared February 2025

5.	Low numbers of births meant that security measures had been more relaxed in relation to an annual abduction drill. In order to ensure continued security, measures need a review.	Review security measures in light of increased footfall. To include - Review of measures in place with low birth numbers - Plan for when numbers increase.	Delivery of Safe and Effective Care	A desk top abduction drill will be implemented to test current protocols and identify any gaps in practice.	All staff members Senior Midwifery Manager	By 14 September 2025
				Identification bracelets will be issued to both mothers and babies to enhance security in the unit. Staff have been emailed on 6 August 2025 for assurance.	All staff members Senior Midwifery Manager	6 August 2025
				A live annual abduction drill will be reinstated if birth numbers increase to ensure staff are familiar with local policies and guidance in line with real time scenarios.	All staff members Senior Midwifery Manager	Annually
6.	The leadership structure for maternity is small across the health board and a review was looking to	Continue to review and strengthen leadership structures.	Quality of Management and Leadership	ABUHB will continue to review and strengthen leadership structures within maternity services, with a particular focus on enhancing strategic oversight and operational resilience. Discussions	Corporate/ Executive Board	January 2026

strengthen the structure.			regarding the establishment of a Director of Midwifery post have progressed to corporate and executive levels, reflecting a shared recognition of the need to bolster senior leadership capacity. This proposed role is envisioned to provide dedicated, high-level professional leadership for midwifery across the organisation, ensuring alignment with national priorities, regulatory standards, and local service transformation goals. The Director of Midwifery would serve as a pivotal link between clinical teams and executive leadership, fostering a culture of excellence, accountability, and innovation.		

				This development in addition to a further consultant midwife post aligns with broader NHS ambitions to empower clinical leaders and ensure maternity services are led by individuals with the expertise and authority to influence system-wide change. The governance Band 8a role will also add additional leadership structure to the senior management team.		
7.	Low numbers of dedicated maternity governance staff in place across the health board.	Ensure governance capacity is sufficient to support the scale of service delivery.	Quality of Management and Leadership	A governance Band 8a role has been shortlisted with interviews planned for 14 August 2025. This role will support enhanced leadership capacity and governance within maternity services.	Head of Midwifery / Assistant Head of Midwifery	By 14 November 2025

				Administration support in place to assist the governance structure, ensuring effective co-ordination and documentation and follow through activities are timely.		

OVERSIGHT AND MONITORING

Oversight and monitoring of the improvement plan will be undertaken by the following groups: -

- Senior Management Team
- Quality Management Group
- Maternity and Neonatal Improvement and Assurance Group

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): **Jayne Beasley**

Job role: **Head of Midwifery**

Date: **14 August 2025**