Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# Hospital Inspection Report (Unannounced)

## Maternity Services, Singleton Hospital, Swansea Bay University Health Board

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

## Our purpose

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

## Our values

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

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

## Our goal

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

## Our priorities

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

# 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 of Maternity Services at Singleton Hospital, Swansea Bay University Health Board on 16-18 March 2026. The wards reviewed during this inspection were Labour Ward, Antenatal Ward including the Bay Birth Unit, Postnatal Ward including Transitional Care, and the Antenatal Assessment Unit.

Our team for the inspection comprised of two HIW senior healthcare inspectors, three clinical peer reviewers (two registered midwives and one registered consultant obstetrician) and a patient experience reviewer.

During the inspection we spoke to 10 women and families and a range of staff, including administrative, clinical, managerial, senior leaders, and board members.

We invited women and families who have used the service in the last 12 months to complete a questionnaire to tell us about their experience. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 32 questionnaires were completed by women and families, and 63 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where appropriate, this report reflects on the findings from our previous inspections conducted at Singleton Hospital's maternity services in September 2023, and in April 2024.

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.

The terms woman/women have been used throughout this inspection report, as this is the way the majority of those who are using maternity services will identify. However, it also includes those whose gender identity does not correspond with their birth sex or who may have a non-binary identity.

# 2. Summary of inspection

This inspection was the third undertaken of the maternity services at Singleton Hospital since 2023, following those completed in September 2023 and April 2024.

The health board is making steady progress, demonstrating ongoing improvements in several areas that previously required improvement. Some examples include better multidisciplinary team working, more effective medical handovers, stabilised leadership, stronger systems for reviewing patient acuity and escalating issues, and improved engagement with senior committees and governance processes within the health board.

However, some challenges remain as highlighted through staff feedback, particularly negative opinions about staffing overall. These concerns extend beyond staffing levels and also relate to the availability of other key clinical and support roles. A key area of focus resulting from the inspection includes implementing an improvement programme for the postnatal ward.

## Quality of Patient Experience

Overall summary:
We gathered survey feedback from women and their families who had used the maternity services at Singleton Hospital over the past 12 months. Of the 32 responses received, the majority rated their overall experience as very good or good. Most women reported being treated with dignity and respect, feeling listened to, and involved in decisions about their care. A significant portion felt supported during labour and confirmed that their birth preferences were respected, with pain relief and the presence of birth partners meeting expectations.

Postnatal care was generally described positively, with most women understanding their care plans and available support. However, restricted visiting hours and limited staff availability during these periods were noted as challenges, particularly affecting timely support and assistance with personal care and infant needs. Some staff feedback highlighted instances where some were visibly overworked, and communication could be improved, but these concerns were in the minority and reflected wider pressures acknowledged by senior leaders, who had initiated an improvement programme.

The service demonstrated a commitment to person-centred and equitable care, with staff routinely considering individual cultural, religious, and personal circumstances, and making onward referrals for mental health needs when

required. Communication needs were actively addressed, with initiatives for women whose first language is not English or Welsh, and support provided for those with hearing impairments. Staff had received mandatory training in equality and diversity, and efforts were made to engage and support diverse groups including tailored resources for Gypsy, Roma, and Traveller communities.

Overall, the service user feedback reflects a maternity service that is responsive and compassionate, while recognising areas for improvement in staff capacity and communication, particularly in postnatal care. The service should use the feedback provided to inform ongoing service developments and ensure that both positive and negative experiences contribute to future learning and enhancement of care.

This is what we recommend the service can improve:

- The Active Offer of the Welsh language must be strengthened
- Less positive patient feedback must be reflected and acted upon.

This is what the service did well:

- Notable patient feedback was provided for the labour ward
- Improvements continue to be made to the bereavement suite
- Initiatives to empower women and to support ethnic minority groups and those with protected characteristics under the Equality Act 2010 were well established.

## Delivery of Safe and Effective Care

Overall summary:
Overall the delivery of safe and effective care for women and babies was well managed. There had been significant development regarding several areas previously identified as needing improvement, including quality of handover, midwifery-led scanning, and processes relating to the Antenatal Assessment Unit (AAU).

We found routine completion of environmental audits, resulting in wards that were well organised and free from obvious hazards.  Security measures, such as locked ward areas and buzzer access, were in place to prevent unauthorised movement of babies, supported by annual staff training. Staff also demonstrated good compliance with training in violence and aggression management and had access to on-site security. Known risks were proactively discussed at daily safety huddles, contributing to effective risk mitigation.

Clinical protocols, including bedside access to PROMPT algorithms and neonatal proformas supported time-critical care. The implementation of the Maternity Early Warning Score tool also enabled staff to consistently identify deteriorating women,

with audit activity confirming its integration into practice. Protocols were in place for women needing transfer for intensive care at Morriston Hospital and an Intensive Care Standard Operating Procedure had been introduced to support this, with any non-compliance reported to the Perinatal Group. However, concerns remain regarding the adequacy of the second theatre on the maternity ward, and a standard operating procedure is in place for urgent use, but clarity around risk assessment processes and their implementation is needed.

Staff reported occasional challenges in promptly sourcing essential medical equipment, such as CTG machines and blood pressure monitors, and needed to source these from other clinical areas when the labour ward was busy. Omissions in record keeping was evident for daily checks of resuscitaires and was addressed through our immediate assurance process.

Medicines management practices appeared to be safe, with correct administration and appropriate arrangements for controlled drugs. Staff had good access to an on-call pharmacist and emergency drug stores, and emergency drug trays for postpartum haemorrhage were pre-filled and centrally stored to prevent delays. Infection prevention and control measures were robust, with regular audits and plans in place to address identified deficiencies. Staff adhered to good hand hygiene practices and maintained bare below the elbow standards.

Safeguarding was well understood by staff, with clear escalation routes. Compliance with safeguarding and other key training was good. Active safeguarding matters were discussed during daily huddles, ensuring cross-departmental awareness, particularly for vulnerable groups.

While patient records were generally completed to a good professional standard, the legibility of handwriting and signatures was highlighted as an area for improvement, though the transition to an electronic patient records system is expected to resolve this.

Multidisciplinary team working was effective and collaborative, and handover processes had strengthened since previous inspections. Concerns remain regarding medical cover on the AAU and postnatal ward, prompting recommendations for the development of escalation procedures to support midwives and maintain patient flow. Overall, the health board is advised to continue monitoring staff feedback, address identified risks, and support improvements to ensure the ongoing delivery of safe and effective care.

Immediate assurances:

- Checking and recording of resuscitaires.

This is what we recommend the service can improve:

- Ensure adequate availability of and access to medical devices
- Develop or revise a brief escalation process for midwives to seek timely obstetric reviews.

This is what the service did well:

- The service was visibly clean and well organised
- Good use of standardised clinical tools and pathways for time sensitive clinical situations
- Good processes for identifying and accessing emergency drug trays.

## Quality of Management and Leadership

Overall summary:
The inspection found that the service had made notable progress in strengthening management and leadership. Staff feedback and survey responses enabled a comparison between recent and previous inspections. Positive trends emerged, including an increase in staff recommending the service as a place to work and greater satisfaction if care were provided to staff's friends and family. Improvements in senior management visibility and communication were also observed, though some challenges persist.

Senior managers demonstrated engagement and commitment throughout the inspection, with recent structural changes unifying maternity and neonatal services under a perinatal service structure. This restructuring, guided by recommendations from an independent review, aims to strengthen governance and leadership. Evidence of cohesive clinical oversight, service improvements, and more streamlined governance reporting was seen, with ongoing internal reviews supporting evaluation of the new structure's effectiveness.

Staff felt well supported, particularly by Band 7 managers and clinical supervisors, and praised both mandatory and specialist training. However, concerns were raised regarding staffing levels, workload pressures, and professional development, with only a minority feeling staffing was adequate or that they had received appropriate mentorship. The health board must address these concerns, particularly in the postnatal ward, and ensure swift progress on improvement initiatives to protect staff wellbeing and patient safety.

Staff feedback also highlighted areas for improvement in preceptorship and training, especially in neonatal skills and transitional care. The health board is urged to conduct training needs analyses and ensure ongoing support for staff development.

The service has maintained robust engagement with women and families, seeking feedback at multiple stages and ensuring learning is cascaded throughout the service. While most feedback was positive, any outstanding concerns were being addressed appropriately. The service's commitment to quality improvement and research was evident, with staff actively participating in national programmes and audits to benchmark and enhance care provision. Collaboration with partner organisations and a review of clinical guidelines are ongoing priorities.

In summary, the inspection found improvements in management and leadership, with a clear commitment to staff engagement, quality care, and continuous improvement. Nonetheless, further work is required to address workforce and professional development challenges and ensure the effectiveness of the new perinatal structure.

This is what we recommend the service can improve:

- Less favourable staff feedback must be reflected and acted upon
- Ongoing improvement initiatives related to postnatal and transitional care must be delivered with pace
- Staff feedback regarding aspects of training, professional development and preceptorship processes should be reflected and acted upon.

This is what the service did well:

- Mandatory and maternity specific clinical training was highly compliant for all staff groups
- Leadership was stabilised and focused on service improvement
- Staff were seen to work diligently and in control, with a sense of calm felt across the service.

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

We invited women and families who have used this maternity service in the last 12 months to complete a survey. We received 32 responses, mostly from women.

Overall, 80% of respondents rated the service as ‘very good’ or ‘good’. Most women had given birth at the time of completing the survey, with two thirds of respondents having received consultant-led care, with the remainder receiving midwife-led care.

### Care during pregnancy and labour

Most women felt staff treated them with dignity and respect, felt listened to, and involved in decisions. Fewer women, around two-thirds, told us that staff asked about their emotional wellbeing during pregnancy.

Women spoke positively about the birthing experience, with the majority giving birth in their preferred place, feeling supported during birth, and having their birth wishes listened to. Most patients also confirmed that the pain relief they receiving during labour was adequate. All respondents confirmed that they received one-to-one care during the birth and were able to have their birth partners present as long as they wanted.

### Postnatal care

Of the 25 women who received postnatal care, most confirmed that they were told what was happening with their care, what to expect, and the ways in which additional support could be provided. However, half of respondents highlighted challenges with restricted visiting hours, particularly regarding a lack of timely support from staff during restricted hours. Less positive feedback related to support to wash or bathe, and to help their baby to sleep.

Whilst we received many positive comments, some expressed dissatisfaction with aspects of the care provided. Common themes regarding postnatal care included: a lack of staff to respond women’s needs in a timely manner leading to instances of affecting patient dignity, references to visibly overworked staff, and the need for strengthened communication.

These comments were however in minority of the overall feedback provided by women and were aligned to some of the pressures described by staff who work on the postnatal ward. Senior leaders were aware of feedback themes from service users, and from staff working in the service, which is consistent nationally. Senior leaders were in the early stages of proactively delivering an improvement programme. A recommendation in this regard has been made later in the report.

Due to the number, length, and highly individualised nature of some of the patient comments received, where agreed, anonymised comments will be shared with the service to ensure that complements can be shared, and learning actioned appropriately.

## Person-centred

### Health promotion

Women were provided with health promotion material and lifestyle advice prior to birth during their antenatal care journey via community midwives and at antenatal clinics. This was confirmed in all the records that we reviewed.

In labour ward and within the Bay Birthing unit, we reviewed hard copy folders of advice and information, that were available in each room, to help inform women and birthing partners and support their decision making. Staff could also use QR codes on patient notes, offering quick access to current information on specific topics and helping staff to share consistent guidance.

### Dignified and respectful care

We observed staff introducing themselves to women and families, maintaining a sense of calm and professionalism during challenging situations, and speaking in a compassionate tone. Overall, 84% of women who responded to our survey agreed that staff treated them with dignity and respect.

It was positive to find that improvements had been made to the bereavement room, including the addition of a pull-down double bed to enable partners to stay overnight, and making this room more homely. Plans were also in place to source a local artist to decorate the room, giving it a more homely feel. Other areas of the service, such as the midwifery led Bay Birthing Unit, provide a less clinical environment for childbirth for low-risk pregnancies. Features included low lighting and access to birthing pools.

Women and families were supported by a specialist bereavement midwife, and other midwives with an interest in bereavement support had received training and upskilling to help ensure support is widely available. The role of the specialist bereavement midwife is not a full-time position, and the health board should

consider the resilience of this role in times of planned or unplanned absences of the current postholder.

**Individualised care**
Staff assessed and discussed women's cultural, religious, spiritual and personal circumstances during their antenatal care. All but one record contained a birth plan, with documented discussion around birthplace choices and other preferences. Any mental health needs were also assessed, with onward referrals made to the perinatal mental health team when required. Overall, antenatal care plans and records were clear, well documented, and individualised to each woman.

It was positive to see 'BRAIN' (benefits, risks, alternatives and nothing) posters displayed in each patient room on the labour ward. These encouraged women to speak up, ask questions about their care, and supported them to make fully informed decisions that felt right for them.

## Timely

**Timely care**
During the inspection, we observed staff working efficiently to meet patient needs, including responding promptly to call bells and other requests. However, staff feedback highlighted clear challenges in consistently being able to deliver timely care and the level of support they would like to provide to women and families.

From a patient experience perspective, timely management of most areas of care was evident, except for the postnatal ward, and also some comments relating to delays in induction of labour, and the need for strengthened communication on the AAU. Other aspects relating to timeliness from a clinical perspective are set out later in this report.

## Equitable

**Communication and language**
We confirmed that the communication needs of women were routinely considered and responded to by staff.

Most women felt listened to and involved in decisions about their care. Whilst several positive comments were received, others indicated that communication could be improved when there are delays in care, communication between specialist midwives and other medical specialists, and comments suggested abrupt or curt responses.

It was positive to find that the service had developed initiatives to support women whose first language was not Welsh or English. This included an access card for women to present at the AAU to help overcome communication barriers that might arise during a telephone assessment. Language Line was also available and accessible on an iPad for ease of use.

Welsh-speaking staff were available; however, use of the 'Iaith Gwaith' logo or badge was not visible, and staff were unaware of how they could obtain one. Staff did confirm that they would ordinarily be able to meet the needs of Welsh-speaking women.

**The health board must ensure that the Active Offer is embedded within the service, particularly amongst new staff.**

It was also positive to find that one staff member was trained in British Sign Language (BSL) to support people with deafness.

**Rights and Equality**

We identified several positive initiatives by staff to engage with diverse groups who may not frequently have their voices heard in healthcare settings, aiming to support these women in gaining a better understanding of their maternity care and available treatment options. This included providing tailored information materials related to pregnancy for members of Gypsy, Roma, and Traveller communities, to help overcome barriers to accessing services.

We confirmed that staff had received mandatory training in diversity and equality, with high levels of compliance observed.

# Delivery of Safe and Effective Care

## Safe

**Risk management**
Environmental audits were completed consistently by ward managers and the matron, to identify and respond to any environmental issues impacting the safety of mothers, babies, visitors, and staff. Upon our arrival, and throughout the inspection, the wards were generally well organised and free of obvious hazards, except for a small amount of unsecured COSHH (Control of Substances Hazardous to Health) materials. **This was resolved at the time of the inspection.**

All ward areas were locked and controlled by buzzer access. Systems, were in place to prevent unauthorised movement of babies on and off the wards, supported by annual staff training.

There was good staff training compliance in the management of violence and aggression, and staff had access to on-site security when required. Known risks were discussed at daily safety huddles to proactively mitigate potential risks to women, babies, or staff.

On the labour ward, staff had bedside access to PROMPT (Practical Obstetric Multi-Professional Training) algorithms, and neonatal proformas to guide the delivery of time-critical care through a standardised, evidence-based approach. This was supported by pictorial posters to help staff recognise time-critical equipment.

For women at risk of clinical deterioration or requiring intensive care, the established patient transfer protocol with neighbouring Morriston Hospital remains the standard clinical pathway for this small subset of women. On review of the latest perinatal committee paper, it highlighted that noted that no obstetric maternal admissions had been made since September 2024. Since our previous inspection, an Intensive Care Standard Operating Procedure had been implemented, and where applicable any non-compliance with this procedure must be reported to the newly established Perinatal Group. Longer-term solutions, including perinatal and ICU co-location, were reported to be under consideration, with the service currently benchmarking its existing clinical provision against other services in the UK. The issue remains on the perinatal services risk register.

The All-Wales standardised Maternity Early Warning Score (MEWS) tool had been implemented to support staff to consistently identify deteriorating women. This

had also been embedded into PROMPT training, and an audit had been undertaken to assess the extent to which it had been embedded in practice.

All elective caesarean sections take place in the main hospital theatre, which is located away from the antenatal and labour wards. Two theatres remain in use on the labour ward for obstetric cases. However, one of these remains small in layout and challenging to complete all obstetric theatre-based care, although it was noted that this is not routinely used. When it is required for use, a standard operating procedure is in place, which includes a risk assessment to support the clinical decision maker about which procedures are undertaken, such as ventouse or forceps delivery. We reviewed this SOP and recommend it is reviewed to ensure clearer guidance for the relevant decision-maker. This should include clarity of the process, how it is implemented and monitored to ensure safe delivery of care. Staff confirmed that a revision to this document was imminent.

**The health board will benefit from reviewing its current second theatre SOP to ensure clarity of process for the clinical decision maker.**

**Infection, prevention and control and decontamination**
The service was visibly clean and generally well organised. Staff were clear on how to fulfil their roles in relation to IPC, with support from domestic staff as required.

IPC audits were regularly completed by ward managers, with oversight from the matron. A recent corporate IPC team audit had identified some deficiencies, but we observed plans in place to remedy these issues in a timely manner.

We witnessed staff adhering to good hand hygiene, and all to be bare below the elbow.

**Safeguarding of children and adults**
Staff we spoke with demonstrated a good understanding of how safeguarding applies to their roles and duties. Staff described clear routes for escalation, support, and guidance, and all reported feeling able to respond and deliver care appropriately. They also confirmed that clear communication existed with community midwifery teams to support the identification and management of risk and to ensure appropriate support for women prior to admission.

This was supported by good compliance in both face-to-face safeguarding training and Violence Against Women, and Domestic Abuse and Sexual Violence (VAWDASV) training. Staff were also supported by specialist midwives for safeguarding, mental health, and bereavement, who engaged directly with women and families when required.

Active safeguarding matters were discussed at the daily safety huddle to ensure awareness and appropriate risk mitigation. We observed this to include examples, such as induction of labour for women under the age of 18, to ensure cross-departmental awareness.

**Blood management**
There were appropriate blood management systems in place, including timely access to blood products. However, staff expressed concern that blood samples were transported to Morriston Hospital on an hourly basis for testing, which has potential to cause delays in care and treatment.

As identified in a previous inspection, we confirmed that procedures had been revised to ensure that urgent samples are flagged as such to the pathology laboratory. The health board is advised to continue monitoring staff feedback, result reporting times, and clinical outcomes in this regard.

**Management of medical devices and equipment**
We confirmed that staff had access to a range of equipment to enable them to deliver care. However, some staff reported that certain equipment, including cardiotocography (CTG) machines, blood pressure monitors, and thermometers, often needs to be sourced from alternate clinical areas when labour ward is busy.

**The health board must review current stock of essential medical devices/ equipment to ensure these are sufficient to meet demand promptly.**

All labour rooms had access to resuscitaires. However, when we reviewed the records for daily checks of resuscitaires, there were omitted entries across several machines. **This was addressed through our immediate assurance process.**

**Medicines management**

Medicines were observed to be managed safely and administered correctly, and staff demonstrated a good knowledge of relevant processes, including the escalation of concerns and clinical incidents.

Arrangements for the storage, administration, and recording of controlled drugs were appropriate. The records we reviewed were completed correctly, supported by routine audit activity.

Staff reported good access to an on-call pharmacist, including out-of-hours availability, with access to emergency drug stores if required. A robust system was also in place to identify medication stocks held on other wards within the hospital, enabling staff to retrieve medicines in time-critical situations.

There were good arrangements in place to access emergency drug trays on the labour ward, including those for postpartum haemorrhage (PPH). Individual trays were pre-filled by pharmacy staff and stored centrally within a clinical area on the ward to prevent delays.

**Preventing pressure and tissue damage**
Within relevant records, we found that patients had been risk assessed for potential skin pressure damage post-caesarean or epidural. We confirmed that the service had access to appropriate pressure relieving equipment, when needed, such as air cushions.

## Effective

**Effective care**
We considered multidisciplinary team working to be effective and collaborative, with a good degree of professional respect and shared responsibility.

We attended a medical handover shortly after our arrival on the first evening of the inspection. Handover processes continue to demonstrate strengthened practice compared with previous inspection findings. There remains scope for midwifery and medical handovers to be further improved when the new electronic patient records system is implemented, which is scheduled for Spring 2026.

On the labour ward, patient-at-a-glance information was fully completed, clinically informative, and continued to provide real-time information to enable effective oversight and communication for staff.

On the AAU, it was positive to see the Birmingham Symptom specific Obstetric Triage System (BSOTS) was fully implemented to enable staff to follow a standardised assessment and prioritisation tool. In December 2025, 87% of women were seen within 15 minutes of arrival into triage. Where time breaches occurred, either due to delays in initial assessment or medical review, efforts had been made since the previous inspection to strengthen reporting through Datix, and staff were aware of their responsibilities in this regard. Other areas for improvement previously identified had been sustained overall.

Some staff expressed concern regarding medical cover on the AAU and postnatal ward. Whilst it was positive to see that a rota system had been developed for the AAU to support consistent coverage, we recommended that this be further developed to support midwives and overall patient flow. Our recommendation included the development of a brief escalation standard operating procedure (SOP) or flowchart to guide escalation to the relevant consultant or on call doctor whenever a clinical need arises. This could include an amendment or addition to the existing ‘Jump Call’ Guideline, or communication to staff to support clarity in

who to call in situations where the on-call obstetric team are not available for urgent clinical matters.

**The health board must ensure it considers implementing an escalation SOP or flowchart to support midwives with a procedure to follow in the event of being unable to a seek timely obstetric review.**

Staff confirmed that women who were triaged as an emergency and classified as 'red', were escalated immediately and without delay.

It was positive to note that improvements had been sustained in achieving third trimester scanning intervals. This was supported by a midwife sonographer team, which had been developed within the health board's own workforce to ensure resilience of this provision.

**Nutrition and hydration**

Women and babies had access to food, water, and appropriate breast milk and formula feeds. Water was readily accessible, and hot meals were available at set times, with these times displayed on posters in patient rooms. Light snacks, including sandwiches, yoghurts, and fruit, were also available upon request.

Where required, intravenous (IV) fluids were monitored and recorded within the maternity bundle to ensure clinical oversight and consistency of documentation.

Women were supported to feed their babies when needed, and pathways were in place, where clinically necessary, to ensure infant nutrition was effectively maintained, monitored, and recorded.

**Patient records**

We case tracked eight sets of patient notes in total, across a range of midwifery, obstetric and different types of births. Overall, we found records to be completed to a good professional standard throughout, with good use of care bundles and detailed clinical narratives.

One area to strengthen is the legibility of handwriting, including signatures, to ensure that staff can be adequately identified. However, the transition to an electronic patient records system will naturally rectify this.

# Quality of Management and Leadership

## Staff feedback

We invited staff to complete a survey to share their views and experiences working within the service. We received 63 responses, including 47 midwives. When compared to our 2024 inspection, we received 62 responses with 49 midwives. This allowed for a comparative analysis between two separate inspections.

Positive trends were noted, with an increase in staff recommending the service as a place to work (50% in 2026 up from 41% in 2024), and more staff reporting satisfaction if care were provided to friends or family (56% up from 52%). Visibility of senior management rose slightly (41% from 39%), and communication improved between senior management and staff (35% from 31%), though ongoing challenges remain.

## Leadership

### Governance and leadership

Senior managers and leaders were fully engaged throughout the inspection process, demonstrating their knowledge of service matters, and commitment to deliver improvements. Recent changes to the divisional structure unified maternity and neonatal services under a single perinatal service structure. This was in response to recommendations from an independent review, with the aim of strengthening governance and leadership.

Examples of cohesive clinical oversight, service improvements, and streamlined governance reporting were evident. An internal review, including staff feedback, will support the health board evaluate the effectiveness and outcomes of the new structure after an appropriate period.

**The health board, in due course, should review the newly implemented perinatal structure to assure itself of its effectiveness, and identify any new opportunities for strengthening processes.**

Two non-executive independent members of the Board, demonstrated a good understanding of the service and spoke positively about improved oversight from ward to board. They highlighted, open and knowledgeable senior leadership, enhanced committee reporting, and supportive executive oversight. Board members' direct engagement with staff and patients was also noted as a positive development.

## Workforce

### Skilled and enabled workforce

Clinical staff were observed working diligently and maintaining a sense of calm across the service. Clinical staff, including students, whom we spoke with generally felt well supported, notably on the labour ward, with particular praise for Band 7 management and clinical supervisors. Positive feedback was also given regarding the fetal surveillance midwife and administrative support from ward clerks.

Our staff survey data indicated some areas for improvement: only 34% felt able to manage conflicting demands (down from 36%), just 14% agreed staffing numbers were sufficient (down from 16%), satisfaction with care dropped to 64% (from 66%), and only 73% (down from 81%) felt they could rely on their line manager for support.

Common themes from survey comments referenced ongoing pressure, burnout, heightened acuity and increasingly complexity of care, and a shortage of midwives, support workers and nursery nurses.

We reviewed a sample period of midwifery staffing rotas and found these to be relatively stable, and improvements were seen in meeting establishment levels compared with our inspection in 2023. Despite this, some staff expressed dissatisfaction with staffing levels, though, it was unclear which clinical areas were most affected. The health board should address this feedback from a service wide perspective, engaging with staff to clarify concerns and identify issues.

In our survey, staffing challenges were particularly noted on the postnatal ward (Ward 20), with concerns over staffing numbers, staff deployment to cover other clinical areas, and generally low morale. These issues reflect national trends, but improvements are required to protect workforce wellbeing, and patient safety and experience. Senior managers confirmed that an improvement programme has begun for this area, though it must progress swiftly.

Despite survey concerns, inspection findings showed improvements in establishment levels since our inspection in 2023, and staff generally reported positive support for each other and from Band 7 managers, with a strong commitment to quality care. Nonetheless, there is still scope for improvement

**The health board must reflect on staff feedback regarding staffing levels and engage with them to address and help alleviate any concerns.**

**The health board must ensure that ongoing improvement initiatives related to postnatal and transitional care are delivered with pace, ensuring that staff and patient feedback is reflected in any changes.**

We found that Birth Rate Plus continues to be used to determine staffing requirements for intrapartum care, though, senior staff expressed it does not fully account for the breadth of roles, integration with neonatal care, and increasingly complexity and theatre based obstetric care. National improvement work is underway to revise the current mandated use of Birth Rate Plus, as highlighted in All Wales Maternity and Neonatal Assurance Assessment.

Notwithstanding the concerns raised by staff, robust monitoring and escalation of staffing concerns have been strengthened, with daily staffing and acuity reviews, clear escalation to hospital site meetings, and reporting to the newly established perinatal committee. The health board must continue to hear staff concerns and ensure they are adequately supported.

Obstetric vacancies included two temporary consultant posts, with interviews scheduled the week following our inspection. Vacancies in Band 6 midwifery and support worker roles, and an over establishment of Band 5 midwives has resulted in a predominantly junior midwifery workforce. This requires reflection in future workforce and succession planning, as overreliance on junior staff may impact perceptions of staffing adequacy.

Professional development, remains and area for improvement: just over half of respondents to our staff survey felt they had received appropriate mentorship or preceptorship since commencing their role. Several comments expressed the need to improve preceptorship, including protected time, and overall staff support.

**The health board must ensure that feedback relating to professional development, along with further feedback from staff, is used to strengthen preceptorship provision.**

It was positive to note that compliance with both mandatory and maternity specific training was high, including PROMPT, fetal surveillance and Gap Grow. Two thirds of staff felt they had received appropriate training to undertake their role. Staff highlighted additional training needs in neonatal skills for the transitional care unit and cannulation, with the former requiring swift action as the new Perinatal Group structure develops.

**The health board must ensure that staff feedback continues to be sought to strengthened training provision. This should include a training needs analysis relating to neonatal skills and for staff deployment to the transitional care unit.**

## Culture

### People engagement, feedback and learning

The service actively seeks feedback from women at five stages throughout their pregnancy via text message. When concerns are raised, contact is made with women and families directly, to gain further insight into their experiences. However, the service should ensure that provisions continue to be made for people who may be digitally excluded

All feedback is reviewed by the Perinatal Women's Experience Forum. A patient experience midwife is in post to support women and ensure that learning and improvement is cascaded throughout the service. Engagement with the Swansea Bay Maternity Voices Partnership has also contributed to service improvement.

A small number of formal concerns remained outstanding at the time of inspection, though these were progressing through the appropriate stages.

## Information

### Information governance and digital technology

During our first evening's tour, staff only areas were observed to contain paper patient records, with doors propped open in several areas. Although the risk was considered low, records must be stored securely to prevent unauthorised access. This was promptly addressed during the inspection.

## Learning, improvement and research

### Quality improvement activities

We found evidence that obstetric and midwifery staff have been actively engaged in research and quality improvement initiatives. With stabilisation of core clinical service provision, staff are now able to dedicate more time and resource to these activities.

A comprehensive audit plan was in place, encompassing nationally mandated clinical audits, health board-wide internal audits, and localised service audits based on staff specialisms, learning and clinical interest.

Staff feedback highlights the need for the service to ensure specific clinical treatment aligns with current national guidelines, such as NICE guidelines. For example, the service doesn't currently undertake Placental Growth Factor Testing (PGIF), although this is recommended by NICE. The service would benefit from undertaking a gap analysis to drive service improvement against national

guidelines, and collaborate with partner organisations to further improve the provision of care.

**The health board should undertake a gap analysis to establish its adherence to national guidelines, and collaborate with other organisations to optimise service improvement.**

## Whole-systems approach

**Partnership working and development**
The service was actively involved in national improvement programmes. Senior managers were committed to benchmarking service provision against other units, and both senior managers and clinical leaders demonstrated a strong commitment to quality improvement and supporting necessary changes within the service.

# 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 |
|---|---|---|---|
| A small amount of COSHH material was observed in publicly accessible areas. | This risks inappropriate access by patients and visitors, which could include young children. | This was escalated to the senior management team. | This was immediately removed and stored in a secure area. |
| Staff only areas contained paper patient records, however, doors were observed to be propped open on multiple wards. | Whilst low in risk, records must be securely stored to prevent unauthorised access. | This was escalated to the senior management team. | Doors were secured in all areas. |
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# Appendix B - Immediate improvement plan

**Service:** Singleton Maternity Services

**Date of inspection:** 16-18 February 2026

Findings

We identified that logs of resuscitaire checks were not being consistently completed on the Labour Ward. This creates a risk that the equipment may be unavailable for use in a time-sensitive situation.

The health board must ensure that robust service actions are provided so that improvements in this area are implemented and sustained across all clinical areas.

| Improvement needed | | Standard/ Regulation | Service action | Responsible officer | Timescale |
|---|---|---|---|---|---|
| 1. | The health board must provide details of the actions that will be taken to ensure that resuscitaire equipment is checked on least a daily and immediately after each use to ensure all equipment is functional and present. | Health and Care Quality Standards - Safe | 1. All resuscitaires were checked at the time of the inspection and confirmed to be present and functional.<br><br>2. Update the current Safety Briefing to include the daily reminder that checks have been completed on all resuscitaires.<br><br>3. Revise the daily safety huddle to include a daily checklist including compliance with safety checks. | Clinical Director (Midwifery)<br><br>Labour Ward Manager<br><br>Deputy Head of Midwifery | Complete<br><br>28th February 2026<br><br>28th February 2026 |

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| | | | 4. Hold a Band 7 meeting to discuss the finding from the inspection. | Head of Midwifery | 31st March 2026 |
| | | | 5. Include a spot check audit of compliance against standard within the current regular Matron's audits. | Acute Matron Singleton Hospital | 31st March 2026 |
| | | | 6. Implementation of Badger Maternity EPR includes a mandated field for resuscitaire checks. | Informaticist Lead Midwife | 1st April 2026 |
| | | | 7. The service will explore with Digital colleagues the potential of the introduction within SIGNAL of a flag for resuscitaire checks. | Informaticist Lead Midwife | 1st April 2026 |

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):** **Sharron Price**

**Job role:** **Group Nurse Director**

**Date:** **24/2/26**

# Appendix C - Improvement plan

**Service:** Maternity Services, Singleton Hospital

**Date of inspection:** 16-18 February 2026

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. | Risk to patient experience | The health board must ensure that the Active Offer is embedded within the service, particularly amongst new staff. | Health and Care Quality Standards 2023: Equitable | Integrate a short, standardised Active Offer induction module for all new maternity staff, plus quick-reference prompts on ward boards. | Head of Midwifery | June 2026 |
| | | | | Add 10-minute Active Offer briefing to maternity and medical induction. | Clinical Lead for Obstetrics and Head of Midwifery | June 2026 |
| | | | | Display “Active Offer at a Glance” posters already used in other HB areas. | Head of Midwifery | June 2026 |

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| **2.** | Risk to safe and effective care | The health board will benefit from reviewing its current second theatre SOP to ensure clarity of process for the clinical decision maker. | Health and Care Quality Standards 2023: Safe | Conduct a focused SOP review with obstetric leads and theatre teams to clarify clinical decision maker responsibilities. | Clinical Director for Perinatal and Gynae<br><br>Labour Ward Obstetric Lead<br><br>Lead Intrapartum Midwife<br><br>Theatre Team | September 2026 |
| **3.** | Risk to safe and effective care | The health board must review current stock of essential medical devices/ equipment to ensure these are sufficient to meet demand promptly. | Health and Care Quality Standards 2023: Safe | Complete an inventory and demand versus utilisation check of key equipment (e.g. CTG (cardiotocography) units, neonatal resus equipment, pumps). | Deputy Head of Midwifery<br><br>Acute Midwifery Matron<br><br>Antenatal, Postnatal, Labour Ward Managers | July 2026 |

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| **4.** | Risk to safe and effective care | The health board must ensure it considers implementing an escalation SOP or flowchart to support midwives with a procedure to follow in the event of being unable to a seek timely obstetric review. | Health and Care Quality Standards 2023: Safe; Timely | Create a simple, colour coded escalation flowchart for midwives when obstetric review is delayed. | Clinical Lead for Obstetrics<br><br>Antenatal Ward Manager<br><br>Intrapartum Lead Midwife | July 2026 |
| **5.** | Risk to management, leadership and governance | The health board, in due course, should review the newly implemented perinatal structure to assure itself of its effectiveness, and identify any new opportunities for strengthening processes. | Health and Care Quality Standards 2023: Leadership; Effective | Undertake a light touch effectiveness review of the perinatal governance structure. | Director of Midwifery<br><br>Associate Service Group Director<br><br>Associate Service Group Medical Director | October 2026 |
| **6.** | Risk to workforce | The health board must reflect on staff feedback regarding staffing levels and engage with them to address and help alleviate any concerns. | Health and Care Quality Standards 2023: Workforce | Use existing forums (Staff huddles, drop ins) to gather structured insight and share actions. | Head of Midwifery<br><br>Deputy Head of Midwifery | May 2026 |

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| | | | | Add “staffing pressures and solutions” as a standing agenda item in huddles.<br><br>Ensure Datix reporting for staffing that is assessed as below required levels.<br><br>Share acuity data with Staff to build transparency. | Directorate Manager | |
| **7.** | Risk to patient experience, safe and effective care, and workforce | The health board must ensure that ongoing improvement initiatives related to postnatal and transitional care are delivered with pace, ensuring that staff and patient feedback is reflected in any changes. | Health and Care Quality Standards 2023: Multiple standards | Re-launch postnatal and transitional care (TC) workstream using existing TC project group.<br><br>Co-design with patients (through Maternity Voices Partnership).<br><br>Share changes via safety huddles and newsletters. | Deputy Head of Midwifery<br><br>Acute Midwifery Matron<br><br>Postnatal Ward Manager | September 2026 |

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| **8.** | Risk to workforce | The health board must ensure that feedback relating to professional development, along with further feedback from staff, is used to strengthen preceptorship provision. | Health and Care Quality Standards 2023: Workforce | Update the preceptorship model using insights from the latest cohort.<br><br>Strategy for listening is embedded in the service as part of SEWR (Staff Experience, Wellbeing and Retention) Plan. Staff representatives are embedded in Task and Finish groups to ensure staff voice in solution planning.<br><br>Monitor via SEWR Plan. | Head of Midwifery<br><br>HR Business Partners | September 2026 |
| **9.** | Risk to workforce | The health board must ensure that staff feedback continues to be sought to strengthened training provision. This should include a training needs analysis relating to neonatal skills and for staff | Health and Care Quality Standards 2023: Workforce | Complete a training needs analysis (TNA) focusing on neonatal competencies for midwives and nursery nurses deployed to TC. Map current competency levels.<br>--- | Head of Midwifery | August 2026 |

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| | | deployment to the transitional care unit. | | Prioritise NLS (Neonatal Life Support), TC care competencies, and feeding assessments.<br><br>Align training opportunities with roster planning.<br>---<br>PADR compliance supports ongoing review and discussion surrounding competencies, training needs and development objectives which are aligned to Job Descriptions and our Workforce Plans. | Matron for Neonatal Services. | August 2026 |
| **10.** | Risk to effective care | The health board should undertake a gap analysis to establish its adherence to national guidelines and collaborate with other organisations to optimise service improvement. | Effective; Learning, improvement and research | Undertake a maternity specific gap analysis using existing audit and CNST (Clinical Negligence Scheme for Trusts)/Once for Wales frameworks. | Lead Midwife Quality Improvement Practitioner for Maternity Services<br><br>Lead Nurse Quality | November 2026 |

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| | | | | | Improvement Practitioner for Neonatal Services | |

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):** **Ceri Gimblett**

**Job role:** **Service Group Director**

**Date:** **9th April 2026**