GIG CYMRU NHS WALES

Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

HEIW Education & Training Targeted Visit Report

Obstetrics and Gynaecology

Singleton Hospital

Swansea Bay University Health Board

Friday, 8th May 2026

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Section One: Visit Remit

Health Board	Swansea Bay University Health Board	**Site**	Singleton Hospital
Visit Date	8th May 2026	**Risk Rating (Pre visit)**	**5**
Specialty	Obstetrics and Gynaecology	**Grade(s)**	Foundation, GPST, and ST
Visit Panel	• Malcolm Gajraj, Director of Quality Management (Chair) • Makiya Ashraf, Interim Head for School of Obstetrics and Gynaecology • Frances Hodge, Interim Training Programme Director for Obstetrics and Gynaecology • Zoe Dummett, HEIW Specialty Training Manager • Mandy Martin, Quality Manager • Vicky Collins, Quality Officer • Lisa O'Leary, Lay Representative		
LEP Representatives	• Raj Krishnan, Interim Executive Medical Director • Balwinder Bajaj, Assistant Medical Director (Education and Training) • Madhuchanda Dey, Clinical Director for Obstetrics and Gynaecology • Charity Knight, College Tutor and Consultant in Obstetrics and Gynaecology • Michelle Mason-Gawne, Associate Service Group Director, Children, Young People and Women Services • Sujoy Banerjee, Consultant Neonatologist • Sarah Madden, Assistant Specialty Manager for Gynaecology • Branwen Cobley, Deputy Medical Human Resources Manager • Aishvarya Gupta, Resident Representative • Jacqueline Jones, Resident Representative • Llinos Hodder, Medical and Dental Education Manager - Postgraduate & Undergraduate • Sade Bewsher-Griffiths, Deputy Head of Education and Learning • Georgia Duncanson, Medical and Dental Education Business Support Manager • Bethany Jones, Postgraduate Medical and Dental Supervisor		
Evidence Considered	• Concerns Summary and Evidence Timeline • Health Board Action Plan • Previous Visit Report, 5th November 2025		
Residents Present	7 across GPST and ST grades.	**Trainers Present**	6
Status Summary	• The previous visit was undertaken on **Wednesday, 5th November 2025.** • This concern is not in Enhanced Monitoring status with the GMC.		

In the context of this report, the term 'Residents' refers to Postgraduate Doctors in training unless otherwise specified.

Visit Background

Targeted Visits are the responsive component of HEIW's quality framework. The overall purpose of visits is to support the identification of areas which are working well and those which may require further attention. Evidence obtained prior to and at the visit is considered in relation to GMC standards outlined within Promoting Excellence. The visits provide a constructive way of enabling HEIW and Local Education Providers to collaborate in supporting the provision of high quality postgraduate medical education and training in Wales.

The primary purpose of the visit was to verify that improvements previously implemented were sustainable, as well as to follow up on progress in addressing concerns identified at the previous Targeted Visit in November 2025. These concerns related to unclear handover processes for patients under the care of external and Gynae-oncology teams, along with over-reliance on midwifery staff to ensure postnatal clinic patient information was conveyed effectively. Patient complexity and inconsistent senior supervision had also impacted residents' training opportunities in Emergency Gynaecology clinics. Rostering of consecutive working days impacting residents' work-life balance and inequitable allocation of study leave had also been raised.

The Health Board has indicated the following progress in response to the above requirements and recommendations set during the HEIW Targeted Visit undertaken on **Wednesday, 5th November 2025**.

- The Obstetric Handover sheet had been updated to include a tick box for the Daytime Registrar (departing) to complete confirming Gynae-oncology and Insourcing team handover had been given.
- A verbal handover of the Gynae-oncology patients to the Gynaecology on-call team (Available "SHO" or Registrar grade) would take place between 16:00 – 16:30.
- A nurse-led report to document the on-call clinician who had taken handover from the Insourcing Team would be completed at the end of each weekend.
- An audit process had been organised to verify that the Gynae-oncology and Insourcing Team handover had been given verbally, or by email, and the Obstetric Handover sheet had been updated. The College Tutor would monitor the outcomes of the audit.
- The amended obstetrics handover proforma had been stored on the Health Board's Z-Drive and had also been made available in paper format.
- Completed handover sheets had been scanned weekly and reviewed for compliance, providing audit data and enabling re-audit in future months to ensure sustained adherence.
- A workplace forum had been piloted in January 2026 that would monitor sickness leave in line with perinatal and gynaecology governance frameworks.
- Residents' training requirements had been included as a standard agenda item for Resident Doctor Forum meetings.
- The College Tutor planned to discuss equitable distribution of Educational Development Time and residents' training requirements with appropriate management teams.
- The department had developed a document that outlined each patient's specific needs and requests, as well as their bed number, a detailed handover, and the midwife involved in the patient's care.

Section Two: Summary Findings

Participation in the Targeted Visit process was well facilitated by the department. General Practice Specialty Training (GPST) and Specialty Training (ST) resident attendance was good, which allowed for effective feedback and discussion regarding their training experiences. No Foundation residents attended, so their training experience could not be assessed. Trainer representatives offered input from a different but complementary perspective of the training environment available in Obstetrics and Gynaecology.

The August 2025 induction was informative. Residents who had rotated into the department at other points throughout the academic year found the induction to be brief, but adequate to begin their placements. Provision of fobs to access the labour ward had been delayed.

Initial meetings with Educational Supervisors (ESs) and Named Clinical Supervisors (NCSs) had been arranged promptly. Residents' Personal Development Plans (PDPs) and learning requirements had been discussed and appropriately supported.

Vacancies and extended leave for various reasons had diminished the consultant body's capacity to supervise and train. Department Leads confirmed that a number of consultants were due to return to their posts shortly and funding had also been agreed for an additional consultant and several middle grade doctor posts.

Consultants were approachable and accessible by phone; however, there was reluctance from GPST and less experienced ST grades to contact consultants for advice when support from immediate registrar grade doctors was unavailable.

Department leads confirmed that the number of theatre sessions had increased to meet training demands. Theatres were a beneficial learning opportunity; however, a small number of residents noted their training opportunities in theatres to have been restricted by their ES's primary specialisation.

Consultant participation in formal teaching sessions was reported to be limited. Nevertheless, when provided, consultant feedback for work undertaken by residents was constructive and beneficial learning.

Trainers reported clashes between residents' non-working days and consultants' theatre and clinic days to have impacted training opportunities.

The College Tutor had taken steps to develop customised support for residents in order to alleviate barriers to accessing ultrasound scan training.

Clinics were perceived to be prioritised for service provision rather than training. Several residents noted having been called away from scheduled training opportunities to support ward or theatre workload.

A lack of immediate senior support for Emergency Gynaecology and Postnatal clinics was reported to have contributed to delays and had a detrimental impact on patient experience. Foundation, GPST, and less experienced ST residents also noted the number of patients booked into antenatal clinics to be challenging to manage efficiently.

Senior ST residents raised concerns that the complexity of patients scheduled into Emergency Gynaecology clinics may be too complex for the GPST and less experienced ST residents regularly rostered to cover it.

ST residents valued the opportunity to review patients independently in speciality antenatal clinics but perceived the lack of locally accessible senior support to have reduced opportunities to discuss patient management plans with a consultant.

GPST and ST years one to three residents had not been granted the same levels of Educational Development Time as more experienced ST colleagues. Concerns about the impact of consecutive working days on residents' work-life balance were raised again, having been highlighted in the previous Targeted Visit report.

Evidence of the effectiveness of new handover processes for Gynae-oncology and post-natal clinic patients were reported by consultants and verified by residents. The Directorate's insourcing workload had been completed; however, it was confirmed that handover processes had improved prior to completion.

Trainers' awareness of residents' concerns demonstrated residents' willingness to raise concerns to senior colleagues.

No concerns of challenging or inappropriate behaviours were reported. Consultants confirmed that civility sessions and wellness frameworks had been developed and embedded.

Responsibility for the oversight and auditing of many of the changes implemented following the previous Targeted Visit lay with the College Tutor, who would shortly be vacating their post. Department leads confirmed that succession planning for the post had already begun and an appropriate candidate had been identified.

Overall, senior supervision was sufficient to maintain patient safety; however, constraints with in-person senior support were perceived to have detrimentally impacted patient experience and limited ad-hoc training opportunities.

The majority of residents would recommend their posts for training, provided that more time was dedicated to training and senior support was immediately accessible where needed.

Areas Working Well	Areas for Improvement
• Departmental culture was supportive and inclusive. • No concerns regarding inappropriate behaviours were reported. • Educational supervision was consistent, structured, and effective. • Residents' portfolio requirements were monitored and supported. • Handover processes had improved and were robust. • Consultant feedback was appropriate and constructive. • Civility initiatives and anonymous feedback mechanisms had been established. • Theatres were a good quality training experience. • Residents felt comfortable raising concerns with team members. • Efforts are already being made to address ultrasound training gaps.	• Exposure to ultrasound clinics was limited. • Direct consultant supervision was inconsistent. • Residents had been pulled from training to cover service demands. • Consultant medical leave and rota gaps had impacted training delivery. • Complexity of patients in Emergency Gynaecology clinics was perceived to be inappropriate for GPST and less experienced ST residents. • Some specialty antenatal clinics had not been supervised by Consultant Obstetricians • Training opportunities had been impacted by rota mismatches with consultant availability. • Weekend staffing was insufficient. • Access to Educational Development Time for Foundation and GPST residents was inconsistent. • Consultant-led local, and ward-based teaching was inconsistent.

Requirements and Recommendations

The following requirements and recommendations were made on behalf of the HEIW visiting panel, in response to the findings of the visit process.

Requirements

1. The Health Board must ensure residents are not delivering specialist gynaecology or antenatal clinics without direct supervision.

   GMC Requirement 1.9
   Learners' responsibilities for patient care must be appropriate for their stage of education and training. Supervisors must determine a learner's level of competence, confidence and experience and provide an appropriately graded level of clinical supervision.

2. The Health Board must ensure Emergency Gynaecology clinics are led by consultants or registrar grade equivalent doctors, with less experienced residents present for support and training purposes.

   GMC Requirement 1.10
   Organisations must have a reliable way of identifying learners at different stages of education and training, and make sure all staff members take account of this, so that learners are not expected to work beyond their competence.

3. The Health Board must maintain a record to evidence that requirements 1 and 2 are being met and sustained.

   GMC Requirement 2.11
   Organisations must have systems and processes to make sure learners have appropriate supervision. Educational and clinical governance must be integrated so that learners do not pose a safety risk, and education and training takes place in a safe environment and culture.

Recommendations

1. The Health Board should take steps to ensure that direct consultant support is available for Specialty Training (ST) residents' year 4 and below, during general gynaecology and antenatal clinics.

   GMC Requirement 1.8
   Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence, and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor.
   Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.

2. The Directorate should take further steps to proactively identify residents' learning needs at the beginning of their placements to ensure individual training requirements are deliverable, with consideration for potential staffing challenges, trainers' clinical duties and Less Than Full Time (LTFT) working patterns.

   GMC Requirements 1.7
   Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.

3. Educational Development Time should be consistently available to all resident grades in accordance with appropriate tariffs and guidelines.

   GMC Requirement 3.12
   Doctors in training must be able to take study leave appropriate to their curriculum or training programme, to the maximum time permitted in their terms and conditions of service.

4. A suitable individual should be identified, supported, and appropriately job planned to undertake the role of College Tutor, to ensure the department's positive training environment is sustained.

   GMC Requirement 4.2
   Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.

5. HEIW will visit again in approximately six months.

   GMC Requirement 2.6
   Medical schools, postgraduate deaneries and LETBs must have agreements with LEPs to provide education and training to meet the standards. They must have systems and processes to monitor the quality of teaching, support, facilities, and learning opportunities on placements, and must respond when standards are not being met.

Next Steps

The aforementioned requirements and recommendations were provided to the Health Board verbally on the day of the visit and in writing on **Friday, 8th May 2026.** An action plan has been requested with a response required by **Wednesday, 24th June 2026.**

Risk Rating Recommendation

It was agreed that the current risk rating of **five** (medium) remained in place. A further review of the risk rating would be undertaken at the next Targeted Visit.

Chair's Signature

I confirm that this report has been produced on behalf of the HEIW visiting panel and reviewed by those at HEIW with editorial rights.

Signature: 

Malcolm Gajraj, Director of Quality Management (Chair)

Date: 22nd June 2026