GWASANAETHAU MAMOLAETH A NEWYDDENEDIGOL
Adolygiad Annibynnol o Fae Abertawe

The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board

MATERNITY AND NEONATAL SERVICES
Independent Review of Swansea Bay

July 2025

Report Advisory Notice

This report deals with difficult subjects relating to maternity, childbirth, trauma and emotional distress. We have made efforts to write our report in a way which is not overly descriptive and limits the use of distressing information. However, there are instances where information is necessary, for example, where it is relevant to quote the experiences of women or families and where a specific medical or surgical procedure is described or documented. We do advise caution for those who may be triggered by reading information which might be distressing, particularly, and ask that people seek help to ensure they are able to read this report in a safe and supported way. Help can be accessed via https://www.nicheconsult.co.uk/swansea-maternity-and-neonatal-review/#help

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- Different languages can be accessed via the Health Board Website.
- A summary version of this report is available.
- A Welsh language version of this report is available.
- An ‘easy read’ version of this report is available.

Contents

Foreword by the Chair of the Independent Review,

Dr Denise Chaffer, CBE.

This review was commissioned by Swansea Bay University Health Board (SBUHB) in response to a range of significant concerns about the safety and quality of maternity and neonatal services provided. These concerns were raised by the December 2023 Health Inspectorate for Wales report, MBRRACE-UK reports, and directly by families.

This report has five key components: the voices of families sharing their experiences; a clinical review of cases undertaken by experienced, independent, clinical team; staffing and leadership; a governance review of the Health Board's processes; and, an extensive review of data and outcome information.

During the last twelve months of intensive fieldwork, the review team have come to know a wide range of families and diverse communities, as well as the staff of SBUHB. People have shared with us their stories, their fears and their hopes for the future of services. We particularly thank the families who have provided their time and shared their experiences with the family engagement team. It has been a privilege to work with everyone, and we offer our most sincere thanks for their time and the compassion they have showed to us, and in particular, their offers to work with SBUHB to support their journey of improvement. We also offer our heartfelt thanks to all the staff who have contributed with willingness and candour.

Whilst our work has benefited from comments from over 1000 families, we acknowledge, understand, and respect the fact that some families affected by maternity and neonatal services have chosen not to participate at this time. Our independent self-referral/ triage midwife will continue to be available to support any families who would like to make contact, at any time following the publication of this report.

We found that, whilst many women and families report a mostly positive experience of pregnancy and birth, some women have had and continue to have, a considerably poor or traumatic experience. Some go further and describe instances of severe birth trauma, some of which have occurred in the last year. These include significant issues relating to lack of compassion (in particular very poor responses to harm events), failure to listen, and feeling ignored. We also heard concerns from some of our more seldom heard groups relating to language barriers and lack of cultural awareness.

The clinical review team have reviewed in depth the care given to138 women and 125 babies.

Each individual review represents a family whose experience is unique, and each family rightly expects from the Health Board, openness, compassion, kindness, support and a commitment to learn. The reviews have shown the need to significantly improve the consistency of care delivered to women and their babies, and to ensure learning from every case is identified, disseminated to the entire multidisciplinary team and acted upon to drive improvements in care.

The clinical review team have highlighted the need for the Health Board to introduce additional steps to address the risks of delivering critical care services on a different site to the maternity and neonatal services. Both teams have made key recommendations related to improving the triage process, involving families in reviews of their cases, and greater compassion within their feedback to families.

The review of governance in relation to maternity and neonatal services, has identified significant weaknesses in the period between 2021 and 2024, which in particular, includes the need for

immediate review of the Health Board's complaints processes, improvements to Board reporting and oversight, investigation, risk management and governance processes.

Our review has shown some evidence of improvements since 2024: staffing levels have significantly improved, as has compliance with training requirements, and there has been a gradual improvement in maternity outcome measures, including a reduction in perinatal mortality and morbidity since 2023. This has included some recent improvements in the Health Board's investigation processes, and in implementing the learning from these processes.

This report has shown the importance of always listening to families and ensuring that they are heard and that their experience and needs are always considered and acted upon.

Through our review we encountered a service which has, since 2024, made a renewed commitment to learn, and has listened carefully to the feedback from the review team given throughout the course of the review. New Board positions, such as the Chief Executive, Executive Director of Nursing & Patient Experience and, at the start of this review, a new Chair, are important in redefining the culture of maternity and neonatal services and in SBUHB becoming a listening and more compassionate provider of care. It is essential for the Health Board to demonstrate the importance of rebuilding relationships with women, families and communities, placing them at the centre of care and the design of services.

We welcome the recent statements from the new Chief Executive of the Health Board, giving public acknowledgment of the genuine concerns that have been raised, providing unreserved apologies to families where the care has fallen below acceptable standards, and making a commitment to act. This commitment needs to be held at every level and by every member of staff throughout the organisation, and the Health Board needs to continue to make the much-needed changes which have been evidenced within this report.

We hope this review will give the people who use maternity and neonatal services provided by SBUHB, a report which offers in depth analysis across a broad range of areas, starting with the voices of women and families themselves. There is still much to be done to improve maternity services, and this report serves as a call to action for the Health Board to do more to rapidly improve the experiences of people using these services. This report makes key recommendations to help the Health Board and other responsible bodies in Wales along this journey.

The work of this review does not and must not stop here. A forward plan has been developed to ensure this conversation continues until all the required changes are made, and sustained improvements are demonstrated to the women and families that the Health Board serves.

Dr Denise Chaffer, CBE.

Chair of the Independent Review, July 2025.

Foreword by Sarah Land,

Heidi's mum and co-founder, Peeps HIE (hypoxic-ischaemic encephalopathy).

Thinking of the families

Hearing about concerns around the level of care and safety in maternity services is heartbreaking. Worryingly, these reports are all too frequent in the media. Everyone deserves safe, respectful and compassionate care, especially during a time when many are feeling vulnerable and anxious. This review helps highlight where care has fallen short, and importantly what needs to happen now to do better.

Behind every review, every report, and every statistic is a family - real people whose lives have been profoundly impacted. Some have experienced loss; some have children with lifelong injuries and disabilities; most, if not all, have endured trauma that will stay with them forever.

When that trauma was avoidable, there are added layers of complexity for families to navigate – anger, grief, guilt to name but a few. There's no training manual, and sadly often little support, to help do this.

My contribution to the Independent Review's Oversight Panel has come from my own personal lived experience and my commitment to help improve safety within maternity services. I have a daughter who had a catastrophic brain injury at birth. She is now 10 years old with complex medical needs. I understand some of the challenges families face. I'm not here to speak on behalf of families, as each journey and experience is unique, but I do understand how important it is to be listened to, and for lessons to be learned.

Over the years, I have been in contact with hundreds of families, from different backgrounds, with different experiences and outcomes. What consistently stands out, and runs as a theme through so many conversations, is the drive to make sure that the same doesn't happen to anyone else.

We are especially grateful to the families who have taken the time, and courage, to share deeply personal experiences. Re-living traumatic and upsetting experiences can be so difficult; the drive by families to do this, to push for change for the benefit of others, has not gone unnoticed.

We also acknowledge those families who chose not to take part or did not feel able to contribute. Your decisions were fully respected. We hope that sharing the review findings, even though they may be difficult to read, will offer reassurances that family voices have been heard.

It was vital that families were at the centre of this review, being listened to, with compassion, respect and access to support if or when needed. It is now crucial that meaningful actions are quickly taken by the Health Board, as a result.

I hope this review leads to meaningful change. Trust needs to be rebuilt by the Health Board, so that families see changes, and those who need to use the service in the future can do so knowing it is safe, and that they will receive compassionate care.

Sarah Land

Heidi's mum and co-founder, Peeps HIE (@PeepsHie)

1

1. Summary of report

Introduction

1.1 This review has been commissioned to examine the safety and quality of maternity and neonatal services at Swansea Bay University Health Board (SBUHB) between 2019 and 2023, particularly focussing on data reported during those years by the reports of **Mothers and Babies – Reducing Risk through audits and enquiries across the UK (MBRRACE-UK)**. The main purpose of MBRRACE-UK is to conduct robust national surveillance and investigate the deaths of women and babies who die during pregnancy or shortly after pregnancy.

1.2 Whilst this review has a significant retrospective review element, the review team recognise that one of the most important objectives of this work is to provide information which helps women and families to have confidence and trust in the safety of services today and going forward.

1.3 Three primary factors led to the decision to commission this review:

i. To better understand the reasons behind MBRRACE-UK data and why SBUHB was an (adverse) outlier in some years;

ii. The Health Board remained an outlier and did not seem to make progress despite multiple external reviews and recommendations; and

iii. Some families have raised concerns about the quality of care they had received, the way they had been treated afterwards and the lack of compassion shown in their distress.

1.4 For SBUHB, the MBRRACE-UK data has shown:

- Over the period from 2018 to 2023, 90 stillbirths were reported to MBRRACE-UK, with peaks of 20 in 2020 (this was the Covid-19 pandemic year) and 16 in 2023. Over the same timeframe, 45 neonatal deaths (a live born baby who died up to 28 days after birth) were reported with peaks of 12 in 2021and 9 in 2023. For context, the number of deliveries over the five-year period was almost 17,000.
- The stillbirth rate increased from 2018 to 2020; SBUHB was highlighted as an outlier in 2020 (the Health Board's adjusted mortality rate was more than 5% higher than the average of similar Trusts and Health Boards). However, from 2021 to 2023, the stillbirth rate decreased and was comparable to other peer group organisations.
- SBUHB was an outlier on neonatal mortality rates in 2019, 2021 and 2023 (the Health Board's adjusted mortality rate was more than 5% higher than similar Trusts and Health Boards).
- When viewed together for stillbirths and neonatal deaths, SBUHB was an outlier for three consecutive years between 2019 and 2021, and then also in 2023. In 2018 and 2022, the Health Board's rates were similar to, or lower than, the average for comparator organisations. It should be noted that the MBRRACE-UK analysis is a benchmarking tool that highlights areas that may warrant further investigation by the Health Board; it does not provide definitive evidence of deficiencies in care.

1.5 Many families have come forward to participate in this review and, in sharing their experiences, comments and time with us, have provided this review with invaluable insights into the care they received. The Independent Review team are incredibly grateful to those families who came forward to talk to us with willingness and candour, and for trusting us with their experiences. In total, this review was able to take in the views of around 1,180 women and families and analyse 1,430 statements of feedback.

1.6 This review has considered a broad range of evidence in relation to the experiences of women and families, the quality of clinical care, the governance and leadership, the culture, the experiences and competency of staff and the local and national data available. Using evidence in this way provides a rounded understanding across a range of issues:

1.7 This review has worked with the core ambition of ensuring that the **safety system** surrounding maternity and neonatal services can be optimised. This is known to promote lasting and reliable change and to ensure the safety of services into the future.

The experiences of women and families

1.8 This review has used several different sources of feedback to understand the experiences of women and families. These are a combination of quantitative and qualitative feedback. The Family and Community Voices Steering Group was established to provide assurance on the reach of this review and to discuss practical approaches to engagement. This group included: Llais, the Maternity Voices Partnership (MVP), Peeps, Action against Medical Accidents (AvMA), a family member and members of the review team.

1.9 The main sources of feedback to this review were: comments received directly via the dedicated webpages and web form; the self-referral process; the clinical case review process; and women and families who provided their experiences to Llais as part of their research in October 2024 (and reported in May 2025[1]). Feedback and responses were also provided under the banner of the MVP programme, comments and complaints provided to the Health Board, webinars, focus groups and community outreach activities (such as attendance at shopping centres).

1.10 The review reached out into a range of different communities, public sector stakeholders and major employers locally including: all General Practices and Community Groups (posters were supplied), the Driver and Vehicle Licensing Agency (DVLA) (a major regional employer), the Sketty Mosque, Gypsy, Roma and Traveller Communities, Chinese, Asian and Black heritage communities and the Neonatal Veterans Group.

1.11 In total we analysed 1,430 comments across multiple sources of data to arrive at key themes.

1.12 The review found that, whilst many women reported a mostly positive experience of pregnancy and birth, some women have had and continue to have a poor experience. Some go further and describe examples of severe birth trauma. Whilst some of these predate 2024/2025, there are recent examples of similar concerns. Thematic analysis of these concerns included issues related to: communication and advice; trauma and fear; feeling ignored; compassion and care; informed decision making; access to care; and birth partner and separation.

1.13 Additional concerns from seldom heard groups related to: language barriers and insufficient or ineffective measures to ensure that the family was understanding the treatment being

provided and any choices which might be available; and cultural awareness, such as the importance of respecting women's modesty, and of dietary practices and preferences.

1.14 The review also found particular concerns with the maternity triage system. Advice was inconsistent; there was a lack of supportive advice and information given to women calling the service; there was a lack of senior medical presence in triage, and monitoring of the quality of the triage service was weak.

Clinical findings from detailed case reviews

1.15 The clinical reviews were undertaken by a multidisciplinary team (MDT) comprising experienced senior clinicians. The clinical review team reviewed the care given to 138 women and 125 babies. As part of this, the team reviewed the cases which formed part of the MBRRACE-UK datasets in 2020, 2021 and 2022. The Terms of Reference for the clinical review did not require a review of cases in the most recent MBRRACE-UK dataset for 2023. These cases focussed specifically on cases that resulted in stillbirth and neonatal deaths. In addition, the 2022 cohort also included all babies admitted for neonatal intensive care which included HIE cases. It is likely that many of the findings of the clinical reviews apply to the wider population who access perinatal services.

1.16 There were an additional 22 cases (including 2 self-referrals) added to the Terms of Reference following a site visit which highlighted risks that maternity services at Singleton Hospital are isolated from support services, particularly intensive care. This addition to the Terms of Reference was ratified formally by the Oversight Panel in January 2025, in line with their role.

1.17 The care for these 22 cases was reviewed by a separate obstetric, midwifery and anaesthetic team. 10 of the cases involved neonatal care, which were reviewed by the same neonatal review team. All team members used the same review methods.

1.18 Each case was reviewed independently by all of the reviewers, and findings were recorded on a standardised review tool. All reviewers then came together to quality assure and finalise each review and agree 'modifiable factors' and learning. Modifiable factors are events (or interventions) in care, which, had they been done differently, may have made a difference to that care outcome.

1.19 The clinical review team identified a significant number of inconsistencies in the quality and effectiveness of the care provided across both maternity and neonatal services. Multiple areas of learning were identified, some of which were seen to improve from the cases reviewed from 2020 compared to those from 2022, but others did not improve.

1.20 In all cases where the reviewers found major modifiable factors in obstetric/midwifery care, SBUHB had, through their own internal review process, identified similar findings and had already informed families of their findings.

1.21 The clinical reviews of pregnant women that were admitted to the Intensive Therapy Unit (ITU) between 2020 and 2024 identified a need to further reduce the risk of delivering ITU services on a separate site to the maternity unit. The findings included four key issues: recognition of deterioration, escalation and use of maternity early warning scores (MEWS); provision of enhanced maternal care at Singleton Hospital; provision of outreach maternity-specific critical care at Morriston hospital; and the need to ensure incident reviews and complaint responses are timely, independent and provide opportunities for learning.

Staffing and leadership

1.22 Our review found that, between 2021 and 2024 there were low and inconsistent staffing levels[2] (predominantly for midwifery staff), and low compliance with mandatory training.

1.23 Efforts had been made to address critical staffing risks in the months prior to the HIW inspection in September 2023, however it was this regulatory intervention and subsequent report that consolidated and highlighted the severity of the risk throughout the Health Board.

1.24 Since then, investment in staffing has led to significant improvements, and substantial vacancies are no longer a pressing concern. Despite this progress, translating high-level changes into tangible improvements 'on the ground' remains a challenge.

1.25 The loss of experienced staff (particularly after Covid-19) has left a workforce with a balance tipped towards newly qualified staff, as the need for extensive clinical experience, expertise and specialism has increased.

1.26 We also heard that effective communication is essential in fostering a cohesive culture. Ensuring that staff are kept well-informed about changes and feel supported is vital. While there remains work to be done to develop these key attributes, this workforce displays increasingly positive markers of a culture that promotes good care and values psychological safety.

Governance

1.27 Governance is the 'systems, processes and controls used by an organisation to achieve its objectives (such as for quality, safety and experience).' Between 2021 and 2024 the review found significant weaknesses in governance. These related to lack of challenge and scrutiny from Board members and poor visibility of issues relating to maternity and neonatal services. Responses to harm events were typically poor. There has been a lack of access to timely and compassionate debriefs following birth; a lack of acknowledgement from the Health Board and an absence of unreserved apologies, including a commitment to learn; and poorly written correspondence lacking in compassion.

1.28 Currently, the Health Board has insufficient 'real time' insight into the quality of maternity and neonatal services and a new perinatal dashboard has been developed; this is due to be fully operational in Summer 2025. 'Enhanced Monitoring' has, over the last year, improved insight and the principles of this should be taken forward. Maternity and neonatal services were placed under Enhanced Monitoring by the Welsh Government in December 2023 following the HIW inspection in September 2023. The Board still has gaps in what it sees around the real experiences of women and families using services, the experiences of staff, and core staffing and demand data.

1.29 We found that approaches to risk management have improved, but more work is still required to ensure risk management is used as an effective tool to improve quality and safety.

1.30 Complaints handling, in line with 'Putting Things Right' Guidance[3], has historically been poor. A significant backlog of complaints had developed which has impacted overall response times. The quality of complaint responses lacked compassion, and this is still an issue.

1.31 The quality of incident investigations is poor. Whilst we recognise that the clinical review found the process of review to be generally accurate, we found that some investigations were 'light touch', devoid of any systems analysis and fundamentally lacked any involvement from the families concerned. Additionally, some very serious incidents should have qualified for immediate external independent review. The requirement for independent review has primacy in the interests of safety and learning, even if a legal action has commenced.

1.32 We recognise that this Independent Review came at a time when significant changes were being made to the governance processes applied to maternity and neonatal services, with much of this work having already been initiated in response to external reviews and national initiatives. Examples of sizeable changes recently made, or which are currently in progress include:

- New senior leadership and Board positions since 2024 which include a new Chair, Chief Executive and Executive Director of Nursing & Patient Experience, and changes in leadership structures at a service group and directorate level including a new Clinical Director of Midwifery, Clinical Director of Obstetrics and Gynaecology, Associate Service Group Director and Associate Service Group Medical Director.
- Responsibility for complaint handling has moved to the Executive Director of Nursing & Patient Experience.
- The Chief Executive has made two public statements which include acknowledgement of concerns, an unreserved apology to those who have experienced poor care and a commitment to act to address concerns. These need to be underpinned by meaningful change throughout the organisation. The Chair and the Chief Executive have met with a small number of families affected to hear first-hand their experience and its impact. This needs to be continued.
- Translation services are available, but they need to be reviewed in response to the feedback from families.
- 'Silver' and 'Gold Command' meetings focus on the action plans from the HIW report which are presented at each Board meeting by senior staff from within the service.
- A Perinatal Committee has been established, chaired by the Executive Director of Nursing & Patient Experience.
- There has been improvement in data capture and the introduction of a maternity and neonatal dashboard which monitors service outcomes.

1.33 Further work is still needed on:

- strengthening ward-to-Board assurance and reporting and Board-to-ward oversight, to ensure maternity and neonatal services receive sufficient profile; and
- redesigning service-level governance structures to reflect collaborative and interdependent team approaches between maternity and neonatal services.

1.34 During this review period, the Health Board has introduced some safety enhancements which are detailed in this report, and we have seen a range of key improvements implemented which include the following:

- More staff have been recruited and there are fewer vacant posts; staffing levels are in line with expected safe staffing standards[4].
- Staff sickness rates are higher in maternity serviced than in the neonatal service, but this is, over time, coming down.
- In April 2025, the majority of maternity and neonatal staff were up to date with their training needs.
- Following the rise in HIE cases in 2023 and early 2024, HIE rates have now reduced significantly. More detailed analysis is being done and insight is now greater, although there is still more to do to put that learning into direct and sustained practice.
- Up-to-date analysis from MBRRACE-UK is not yet available, but the (unadjusted) stillbirth rate for 2024 is showing a gradual downward trend.

1.35 The priority recommendations we have made will lead to greater improvements which will be closely monitored over coming weeks and months.

1.36 We found that the interface between the Maternity and Neonatal Clinical Network and the Health Board requires improvement. We found that the Health Board was unable to access

some insights (for example, mortality information) because this was held on the national, shared Datix system. In addition, some risks that maternity and neonatal services are carrying cannot be mitigated or influenced by the Health Board alone.

Next steps and recommendations

1.37 The Health Board has made a commitment to continue this conversation to ensure that any women and families who missed the review, or felt unable to participate, are still able to provide their stories. Particularly:

- the self-referral website will now transfer to the Health Board from the Niche hosting page;
- the review triage midwife will remain in her support role over the next few months; and
- the psychological support put in place through the course of this review, will remain open for the foreseeable future.

Recommendations

We have proposed 10 priority recommendations arising from the findings within this report. These recommendations are supported by more detailed service-specific recommendations which are provided within each chapter.

1) Establish a single point of access for maternity triage for all women

- A major focus is required on improving the quality of triage and access to the service in line with guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM). A standardised and single contact triage process should be available for all women.
- This must include: improving the quality of calls and women's experiences when contacting the service; increased senior medical input; increased midwifery staffing to ensure all women have an initial assessment within 15 minutes; improvements to the environment (ensuring privacy for triage calls); and monitoring and reporting of the service, including inviting feedback from women.
- Maternity staffing (including triage) must be informed by improved predictive modelling of demand and capacity data, taking into account: predicted in-month birth rate, local capacity issues, moderated demographic risk and predicted staffing shortfalls and skill mix. This is a sophisticated but essential data modelling requirement.

2) Delivery of consistent care with senior clinical staff oversight

- **Obstetric care -** Senior clinical staff must have a mandatory presence in operative vaginal deliveries; this includes all rotational deliveries, forceps or assisted breech deliveries. Complex caesarean sections must also be attended to by senior clinical staff.
- **Neonatal care -** Senior oversight of the management of sick babies needs to be more visible within clinical records. This includes clear documentation of thought processes underpinning decision making.
- **ITU care -** The team must include an intensive care consultant and an obstetric consultant and will ideally also include an anaesthetic obstetric consultant and a senior midwife. These roles should be included in the role and responsibilities of the on-call obstetric team, so as to ensure that women in ITU have at least daily contact with the multidisciplinary maternity team.
- **Radiology -** There is an urgent need to provide a full-time paediatric radiology service, or, as a minimum, a full-time reporting service.

3) Implementation of Maternity Early Warning Scores (MEWS)

- Introduce the current maternity-specific early warning score tool to all areas where pregnant women are cared for (ahead of the introduction of the new pan-Wales MEWS tool).
- Maternity early warning scores should be used for all pregnant and recently pregnant women, rather than the National Early Warning Score for adults (NEWS2), wherever they are cared for in hospital (both at Singleton and Morriston Hospitals).

4) Improve quality of Investigations

- Communication following serious adverse events must be prioritised, and appropriate multidisciplinary reviews conducted within reasonable timescales, and in line with MBRRACE-UK and serious incident review guidance.

- The Board must ensure that, where there is a clear trigger for independence or external review, this is actioned; examples would be a very serious incident, serious birth injury, maternal death, or mortality review.
- The Board must ensure greater involvement of families in investigations.
- External input is critical in ensuring that learning from mortality reviews is maximised. Development of reciprocal arrangements with other UK networks to participate in case reviews would ensure a true 'fresh eyes' approach.

5) Delivery of compassionate and trauma-informed care

- Far greater focus is required on the delivery of compassionate care for all. A development programme should be provided for all staff, addressing: team working; compassionate care delivery; just and learning culture; and trauma-informed practice.
- The Health Board must ensure families can trust the mechanisms for debrief, complaints and investigations when things have gone wrong.
- Healthcare delivery must be culturally informed and culturally sensitive with an enhanced understanding of specific religious needs and cultural practices.
- The Health Board must commit to take action where care and behaviours fall below acceptable standards.
- Timely access to psychological support for women must be available, and all care should be based on trauma-informed principles.
- Current staffing levels on the postnatal ward must be reviewed; there is currently a clear indication that staffing numbers are insufficient to meet the needs of women and families; this is an area where poor experience is often described.

6) Improvements in governance processes

- There should be a complete review of governance processes and Board reporting across maternity and neonatal services, including escalation processes, and the structure and terms of reference for all relevant committees. A direct line of sight of maternity and neonatal services through the governance structure is required. This involves definitively ironing out duplication, clear reporting lines and ensuring appropriate clinical representation at key meetings.
- A maternity 'real time monitoring' report must be available to the Board at each meeting. The performance and quality indicators should be supported by qualitative feedback.
- The debrief service should be reviewed, to ensure improved access to the service as well as to ensure that all staff recognise their responsibility to respond to traumatic experiences.
- There should be a full review of the complaints process, to ensure responses are compassionate, timely, and in appropriate detail for the concerns raised.

7) Attendance for all maternity staff for fetal monitoring training

- The service should ensure that all maternity staff attend the All Wales education programme for the interpretation of fetal heart tracings and have access to cardiograph computerised analysis.

8) Develop and implement a robust process for booking and prioritising women undergoing induction of labour (IOL)

- The induction of labour pathway must also be viewed as a priority, so that women do not experience delays with the process. There needs to be a robust system for the prioritisation of all IOL cases, so that the ones with the greatest clinical need take

priority. There is also a need to ensure that induction of labour can be and is scheduled within an appropriate timeframe.

9) **Review and revise all policies and procedures within the maternity and neonatal service to ensure consistent delivery of care**
   - The service needs to review and redesign its approach to ensuring guidelines are in date, including proactively tracking guidelines which may be due to expire, and ensuring that all guidelines have a multidisciplinary review prior to sign off.

10) **Develop and implement a wider engagement plan**
   - There is a need for a significantly increased level of engagement with women, families and communities who are using the maternity and neonatal services at SBUHB, with a particular focus on seldom heard groups.
   - Survey data alone is insufficient to provide a true understanding of the lived experiences of women and families using services. The Board should therefore additionally commit to undertaking at least ten qualitative feedback interviews per month with women who have used the service within the last 6-12 months.

Audit of recommendations

All of the above should be subject to rolling annual audit as part of a Quality Audit Framework. A formal, independent assessment of the implementation of these recommendations should also be completed in 6-12 months.

Additional recommendations for consideration by the Welsh Government:

All Wales approaches could be considered for improvements to maternity and neonatal services in these areas:

1) Putting Things Right guidance requires significant revision to introduce formal approaches to systems thinking, human factors and family involvement in complaints and investigations. There is a fundamental need to make this process less rigid and more compassionate. The triggers for independent review must be clarified and observed.
2) There should be a particular programme across Wales to introduce a Harmed Patients Pathway (all disciplines). For maternity and neonatal services this should fall into line with the similar principles within the Early Notification Scheme (ENS) in England, to ensure that remedy is swift, decisive and non-defensive.
3) Mental health support for women and families requires an All Wales approach. Funding must be provided for access to rapid access psychological support for women and birth partners.
4) In order for The Welsh Risk Pool to achieve its potential in terms of data, benchmarking and providing helpful insights, more resource should be provided adopting the thematic principles of the Patient Safety Incident Response Framework (PSIRF) implemented across England.
5) The Maternity and Neonatal Clinical Network lacks clarity in its function between strategy and operations (for example, ‘cot finder’). Its clinical leadership role must be reinforced. Maternity and Neonatal Clinical Networks should be responsible for the oversight of outcomes and key safety metrics.
6) A review of the capacity of neonatal critical care services in Wales is recommended (as per the British Association of Perinatal Medicine (BAPM) Service and Quality Standards for Provision of Neonatal Care in the UK November 2022). This should include core activity levels, capacity, patient flows, transport services and the Network’s role with regards to

operational consistency and assurance. Particular attention should be given to babies needing surgical assessment.

7) Recent changes to the approach to babies born at extreme preterm gestational ages (less than 24 weeks gestation) in the UK are likely to result in a significant increase in demand for neonatal intensive care. The complex challenges posed by this group of babies are well recognised; BAPM has formed a specific group to consider how best to address them. One likely future approach is to centralise the care of the relatively small numbers of these babies to concentrate expertise and optimise outcomes. There is therefore an opportunity for perinatal services in Wales to lead in the development of a UK-wide approach.
8) Healthcare providers and commissioners need to actively look at high-risk clinical services and seek assurance that outcomes are in line with national standards and that services are safe. Where standards cannot be met, this should be shared transparently within the organisation and escalated so that services can be supported to improve.
9) This review has highlighted shortages in paediatric radiology support. Advances in telemedicine would enable outsourcing of the reporting of X-rays to provide expert interpretation in a timely fashion.
10) Prompt reporting of postmortem results is key to answering questions that bereaved families may have concerning the care that they and their babies received and also facilitates learning and changes in practice for health care professionals.
11) The Welsh Government may wish to consider the applicability of the recommendations made within this report to other maternity and neonatal services.

2

2. Introduction

Background

2.1 This review has been commissioned to examine the safety and quality of maternity and neonatal services at Swansea Bay University Health Board (SBUHB) between 2019 and 2023, particularly focussing on data reported within the annual MBRRACE-UK reports during those years.

2.2 Whilst this review has a significant retrospective element, the review team recognise that one of the most important objectives of this work is to provide information which helps women and families to **understand if they can have confidence in maternity and neonatal services today**. We have included a stand-alone section within this introductory section, which seeks to answer that question.

2.3 The key aims of the review are to identify:

- any harms that have occurred, the extent of those harms and the continued risk of harm today;
- if there was any action which could have been taken to prevent the events;
- if the internal reviews undertaken by the Health Board were appropriate or whether further learning can be identified;
- if there are any themes from the cases and whether the learning and action taken has had a positive impact on the services;
- if there are any leadership, quality, cultural or governance issues in the services and whether there is any support and/or learning for the Health Board to provide/take forward;
- to consider the working relationships between maternity and neonatal services, how they interlink and whether there is any support/learning for the Health Board to provide/take forward in this respect; and
- to consider user experience of the service for five years from January 2019 and staff experience from January 2021.

Developing the review Terms of Reference

2.4 Local Health Boards (LHBs) in Wales are the 'Responsible Body' for planning, commissioning and providing local healthcare services to address local needs[5]. The LHB has delegated authority from the Welsh Government, who provide direct funding to enable the LHB to exercise its functions in relation to the provision of effective healthcare and public health services.

2.5 LHBs have extensive responsibilities in relation to patient safety and service quality; these include the duty to secure:

- the quality of health services;
- the effectiveness of health services;
- the safety of health services; and
- the experience of individuals to whom health services are provided.

2.6 Under 'The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011[6]', the LHB, as the 'Responsible Body' upon awareness of a patient safety concern, MUST take appropriate and proportionate steps to "investigate the matters raised in the notification of a concern in the manner which appears to that body to be most

appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently."

2.7 The review announced via provisional Terms of Reference (ToR) in December 2023 is not the review which has ultimately been delivered. In April 2024, a further draft version of the Terms of Reference was published which significantly expanded the scope of the original review. An extended listening period took place in relation to these ToR and a further version of the ToR was published in June 2024. Those changes are contained within the appendix to this report.

2.8 In January 2025, the Oversight Panel ratified an addition and additional clarification of wording to the Terms of Reference, including:

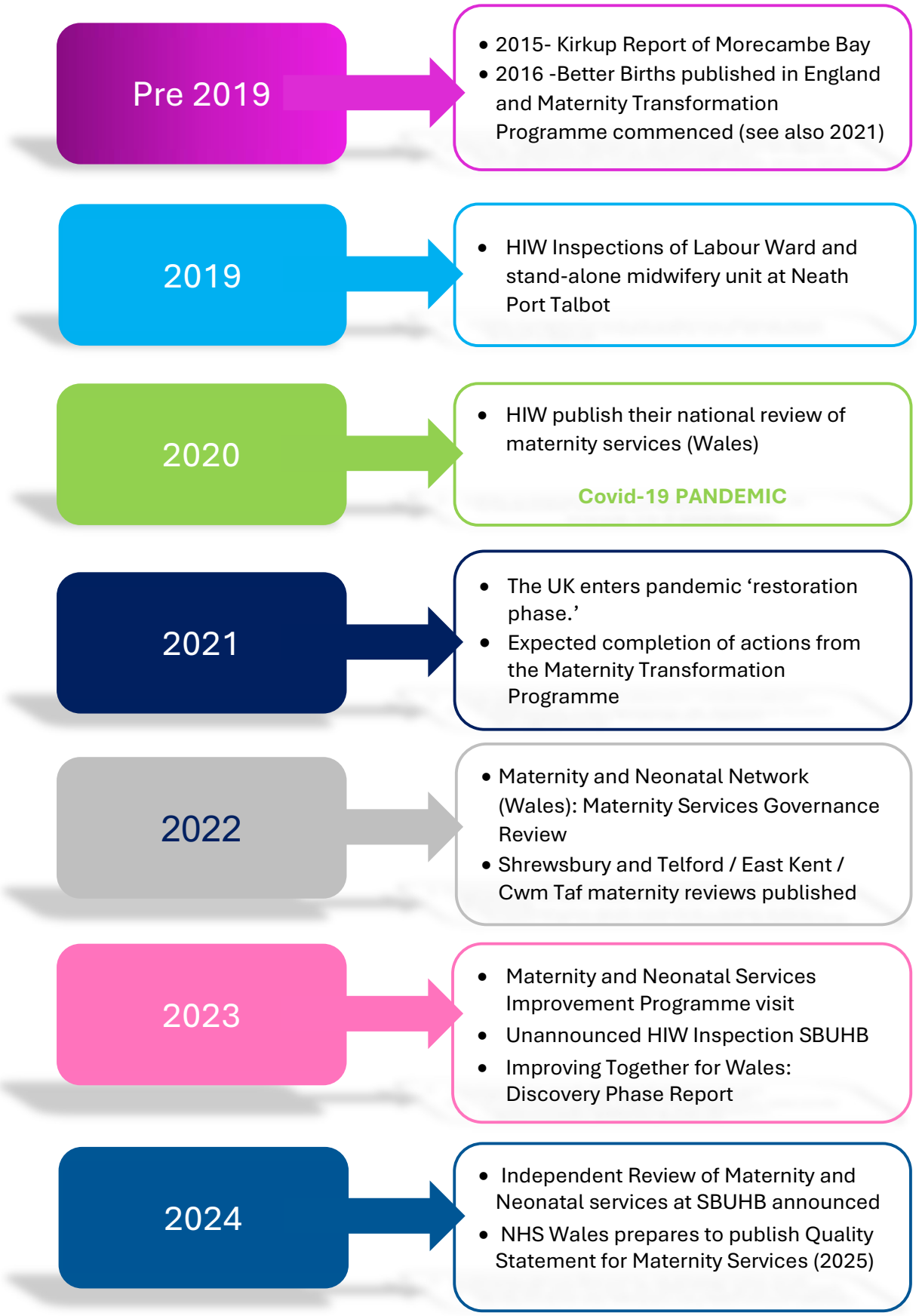
- "[To] Undertake a clinical review of the admissions of pregnant women (including (less than) 6 weeks postnatal period) to ITU during the review period 2020-2024."
- "To seek assurance on the learning from maternal deaths as reported to the Health Board between the same time period."
- Wording change from (6.2): "All babies who had unplanned transfers out to another NIC for ongoing intensive care" to: "All babies transferred out for intensive or high dependency care."
- Wording change from: "All term babies who received unplanned intensive care" to: "All term babies who received intensive care."

2.9 The Terms of Reference for this review also include an analysis of significant impacts arising from the Covid-19 pandemic; instead of addressing this in a single section, references to Covid-19 and associated handling appear throughout the report.

2.10 The full Terms of Reference along with associated changes and the listening exercise undertaken to inform the Terms of Reference are contained within the appendix.

2.11 A contextual review timeline is found on the next page; this sets out key maternity events in England and Wales leading up to the commissioning of this review.

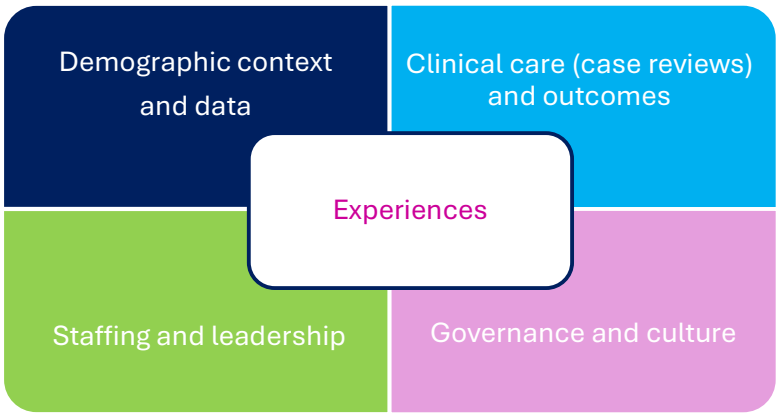
Maternity and neonatal services review timeline



Approach to this review

Understanding care quality

2.12 This review is based on inputs from a multidisciplinary team. Our approach places importance upon a broad range of evidence: the experiences of women and families, the quality of clinical care, governance and leadership, the culture, the experiences and competency of staff and local and national data available. Using evidence in this way provides a rounded understanding across a range of issues:



2.13 This review has remained open to anyone who wished to participate in providing us with their experience. We were able to get a broad range of views to enable us to assess the quality of services at SBUHB. Developing a reliable base of evidence does not involve examining every single case or every single experience as new themes stop being observed within the qualitative and quantitative data. Several maternity reviews which have now been undertaken in England, Northern Ireland and Wales over the last five years, have examined both experience and care provided; the key themes identified are (arguably) now known and researchers can place reasonable reliance upon these findings.

2.14 This review particularly examines whether significant variations exist which are unique to SBUHB when examined against the known and established themes relating to maternity and neonatal services in England and Wales. This review will also examine those features in relation to the specific context of SBUHB; the regulatory environment, the socio-demographic context and in relationship to the care standards which are set.

2.15 This review examines matters which are significant within the context of the scope. We recognise that organisations are continually changing and evolving this was the case over the course of extensive fieldwork for this review. This means that some of the matters identified in this report will already have been revised by the Health Board but were indicated at the time of writing.

Thinking in terms of safety systems – key principles

2.16 Healthcare is an inherently risky and non-linear system, and one where people make errors. Errors and accidents result in harm and adverse outcomes and sometimes in deaths. Approaches to understanding harm which seek out individuals to blame do not generally solve problems and improve safety; this is because people function within systems designed by the organisation, also known as **safety systems**. A safety system recognises the wider context in which incidents occur and focuses upon learning and not blame.

2.17 A safety system includes people, their environment, their training, their equipment and the controls that are applied to their workplace and the culture they work within. The safety

system is also set within a broader system, in this case the Health Board, and, in turn, the Health Board is set within the Welsh care system with partners such as the Healthcare Inspectorate Wales, the Department of Health (Wales), the Welsh Risk Pool and the All Wales Clinical Networks.

2.18 In 2023, the Patient Safety Incident Response Framework (PSIRF) was introduced in England. This evolved from the former Serious Incident Framework to incorporate the latest thinking on patient safety, particularly in relation to the system of work and how individuals are able to work within that system (also known as **human factors**). NHS England have recently launched a 'Being Fair' toolkit[7] which supports organisations to apply balance and fair accountability where staff are concerned.

2.19 A **just culture** is desirable within healthcare organisations and is about striking the balance between blamelessness and individual accountability. Central to a just culture is the need for an open and honest reporting environment, with the aim of a high-quality learning environment and culture. Highly reliable organisations and industries foster mindfulness in their workers. Weick and Sutcliffe[4] describe mindfulness in terms of five key components:

- a constant concern about the possibility of failure;
- deference to expertise regardless of rank or status;
- ability to adapt when the unexpected occurs;
- ability to concentrate on a task while having a sense of the big picture; and
- ability to alter and flatten the hierarchy to fit a specific situation.

2.20 Everyone in an organisation is continually learning, adjusting, and redesigning systems for safety, and managing behavioural choices. **Human factors** is a type of organisational psychology which helps us to both a) understand what went wrong, and b) devise systems to improve safety through recommendations. Human factors methods make it as hard as possible for people to get things wrong in the workplace.

2.21 **SEIPS (Systems Engineering Initiative for Patient Safety)** was initially developed in Scotland and is rooted in human factors thinking. It contains three similar components: the work system, processes and outcomes and their interrelationship. SEIPS prompts us to look for interactions, rather than simple linear cause and effect relationships. When a learning response thoroughly examines the different work system components and their interactions, safety actions can focus on wider system issues, not just on individuals.

2.22 This review has worked with the core ambition of ensuring that **the safety system** surrounding maternity and neonatal services can be optimised. This is known to promote lasting and reliable change and to ensure the safety of services into the future.

The governance surrounding this review

2.23 This is an extensive review involving multiple different areas of focus to ensure a rounded view is achieved. Ensuring and maintaining an effective environment of control around this review has been crucial to ensuring reliable findings and a reliable set of recommendations. The governance surrounding this review has been established to ensure that there are multiple 'checks and balances' along the way.

2.24 This review has also worked on a 'no surprises' basis. This means that, as the review has progressed, if concerns have been identified or issues noted which might affect patient safety, these have been escalated to the relevant team within the Health Board for immediate action.

2.25 When larger reviews are underway which involve any aspect of patient safety, it is good practice to undertake a risk assessment of the current safety environment. If urgent issues

are found, this means that the service can commence any 'make-safe' actions immediately, rather than having to wait until the end of the review; this is also known as a 'current controls' report. This was developed by Niche in 2024 and presented to the Health Board in January 2025 as a working document to ask them to make any urgent changes to the safety environment. Any urgent issues which were found relating to clinical care, have been escalated immediately throughout the course of this review.

2.26 The current controls assessment referenced a significant amount of progress made over the prior 12-18 months, demonstrated by the delivery of all immediate actions identified by the HIW in their inspections in September 2023 and April 2024. However, through our work we identified four compound risk areas which combine several individual but related risks. The key risks identified included:

- Recruitment of large numbers of staff in a short period presents short-term risks associated with ensuring appropriate skill mix, team cohesion, navigating new guidelines and managing times of high acuity.
- Neonatal consultant staffing had been a key pressure due to three members of staff on long-term sickness, although this was mitigated by locum cover and absences were not simultaneous. This was, to a degree, putting the service, the management of neonatal transfers (CHANTS - Cymru inter-Hospital Acute Neonatal Transfer Service), and delivery of key governance activities such as ATAIN (Avoiding Term Admissions Into Neonatal Units) reviews, under pressure.
- Changes have been made to the operational structure at the Health Board and the positioning of the maternity and neonatal services in the service governance structure. Whilst the rationale for this is clearly documented and was subject to both scrutiny and widespread support, the practical implications of this change are that lines of accountability and reporting are not yet sufficiently clear.
- The Health Board is sighted on the challenges associated with incident management (and the significant backlog) and steps are being taken to expedite incident reviews. Coordinated effort is being made to prioritise the review of incidents which indicate harm. However, the backlog raises the risk that learning is missed or delayed due to reviews being undertaken several months after an event (which can also exacerbate poor patient experience).
- There is a gap in the quality of incident reporting provided at directorate, Service Group and Health Board level in relation to the types of incidents and associated clinical harm. Whilst themes are presented, these are too generic to provide adequate insight into whether there is an emerging clinical risk indicated by recent incidents.
- We identified insufficient ultrasound capacity within the Health Board to offer all women serial ultrasound scanning in the third trimester when indicated, or sufficient access to individual scans when required.
- Parts of the estate and some essential equipment for maternity and neonatal services are not fit for purpose and present an increased risk to patient care.

2.27 It is important to note that these were **early findings** aimed only at understanding safety issues which might impede the review from taking place safely. Throughout the rest of our fieldwork, we asked for updates and feedback on how the Health Board was implementing change as the result of our early current controls report. Only this final report can be seen as the fully formed view of the Independent Review of Maternity and Neonatal Services.

Review independence

2.28 The review has five key workstreams (although there are several sub workstreams) with three core teams. These are: the clinical review team; the family engagement team and the governance and analytics team. All members of the review team have been assessed for individual conflicts of interest to ensure independence is maintained at all stages:

- The clinical review team are all working clinicians with extensive experience in their fields (clinical experts). None of them has previously worked on a material basis with this Health Board, but some of the review team do have previous experience of reviewing care in Wales (at Cwm Taf Morgannwg University Health Board (CTMUHB)); this has been helpful to understand the operating context in Wales.
- The family engagement team is also highly experienced. One member of the family engagement team has previously worked on a similar review in Wales (CTMUHB); two people have worked with the Hillsborough group of families as well as on the East Kent Maternity Review, and a further member of the family engagement team has worked on several other large-scale reviews in the NHS.
- The governance and data review elements are being delivered by Niche which is an independent consultancy based in Manchester. Niche have also supported the bringing together of all of the triangulated evidence into one place through this report. They have worked extensively on projects all over the country (including in Wales) undertaking investigations, evaluations, governance reviews and healthcare analytics services (including in maternity and neonatal services).

2.29 The independent reviewers are all working under strict contract terms and funding has been provided via the Health Board who have been supported in aspects by the NHS Wales Shared Services Partnership in the procurement of the contracts under the standard NHS procurement framework. The Health Board is subject to regular external financial audit and must demonstrate probity around the use of public funds.

2.30 The Health Board are the accountable body for the delivery of care in their region[8], and they owe a Duty of Quality to the population that they serve[9]. They are also the legal body which holds the statutory Duty of Candour[10] towards their patients. The Health Board is the body which is registered to hold patient data and the care records. In terms of this review their role has been limited to:

- providing the extensive data and information which is needed to support the review;
- responding to queries, requests for clarification and coordinating contacts;
- approving the overall project plan;
- ensuring the review is funded and ensuring proper financial governance;
- providing factual inaccuracy responses within the draft report; and
- implementing the recommendations and demonstrating improvements where these are identified.

2.31 The Health Board has not been able to influence the findings of this review in any way. Prior to the finalisation of this report, the Health Board were asked to provide factual accuracy representations only. All of these have been carefully recorded, and any resultant changes have been documented.

Sources of feedback

2.32 This review has used several different sources of feedback to understand the experiences of women and families. These are a combination of quantitative and qualitative feedback. The

Family and Community Voices Steering Group was established to provide assurance on the reach of this review and to discuss practical approaches to engagement.

2.33 This group was attended by Llais (the independent body in Wales representing the views of NHS service users), the Maternity Voices Partnership (MVP), Peeps, AvMA (Action against Medical Accidents) and members of the review team. The meeting was attended by a family, and the review team offers them our most sincere thanks for their helpful participation.

2.34 We have used both direct and indirect sources of evidence for gaining an insight into the experiences of women and families. We have also provided quotes which are direct.

2.35 Central to the approach was direct interactions with women and families in either one-to-one conversations, or in focus groups. We were mindful of the further distress that might be caused to people by recounting their experiences. Our team included practitioners with a depth of experience in supporting families to provide their lived experience to reviews such as this, and we also supported women and families to access additional support, such as counselling services, where needed.

2.36 The main channels for feedback into this review included:

- comments received directly via the review's dedicated webpages and the web form;
- comments received via the self-referral process;
- comments and feedback directly via the clinical case review process;
- 515 women and families who provided their experiences to Llais as part of their Maternity Services Insights Report (May 2025);
- feedback and responses under the banner of the Maternity Voices Partnership programme;
- comments and complaints provided to the Health Board; and
- webinars, focus groups and community outreach activities (such as attendance at shopping centres).

2.37 The review reached out into a range of different communities, public sector stakeholders and major employers locally, including:

- all General Practices and community groups (posters were supplied);
- the Driver and Vehicle Licensing Agency (DVLA) as a major regional employer;
- the Sketty Mosque and the Swansea Mosque and Islamic Cultural Centre;
- Gypsy, Roma and traveller communities;
- Chinese and East Asian heritage communities;
- the African Community Centre;
- the Neonatal Veterans Group;
- the Healthcare Inspectorate Wales; and
- the Welsh Risk Pool.

2.38 In total, this review was able to take in the views of around 1,180 women and families. We would like to offer our most sincere thanks for this positive participation and for the willingness of families to engage with us and to help the Health Board to learn.

Equality impact

2.39 An Equality Impact Assessment was drawn up separately (to the Health Board) for this review to ensure that no key groups were disadvantaged in how they could access the review. It was identified at an early stage that digital disadvantage might be a key feature of this review; this was also a key concern advised by Llais. Not all women and families could be assumed to have access to a smart phone or the internet. A key mitigation here was handing out leaflets about the review in shopping centres, focus groups, at in-person visits and providing information to all regional GP surgeries and mother and baby groups.

2.40 A separate website for this review was not established because of timescales and the requirements around data security. An early decision was taken for Niche, as a fully independent firm, to host the review web pages via a microsite so that they could be covered under the existing Niche ISO:27001 and cyber security certifications to assist with the rapid mobilisation of the review and prompt access for families. The access to the self-referral elements of the web pages will transfer over to the Health Board at the cessation of this review.

2.41 There are communities where English is not the first language spoken or read. All review literature has been translated into Welsh and the Health Board website has a global translate facility available. The final version of this review is available in easy read formats, Welsh and via other languages on the Health Board web site.

2.42 We use the term woman, women and female throughout this report as this is how most people who are pregnant and giving birth will identify. This term includes 'birth giver' where people have a gender identity which does not correspond with their gender identified at birth.

The structure of this report

2.43 This report has an important task of combining national research findings and best practice, with local understanding and local findings.

2.44 Because of the nature of the review, this report will contain medical terminology and some references to academic research; this is so that this report can be relevant to families and professionals alike. Wherever possible we have explained what the terminology or clinical reference is to promote accessibility although we recognise that this is not always possible. Key terms used have been explained in the glossary within the main review appendix.

2.45 In order to provide a balance, the section summaries, which form the basis for the overall report summary and abridged report, have been written in plain language and provide a condensed view of the topic. If more detailed information is required, this can be read in the main body of the section and additionally in the appendices.

2.46 Extensive evidence has been used to form the basis of the findings of this report. The most material of this evidence is referenced directly within the report and endnotes or appendices; other evidence is kept as part of the working papers, on Niche secure client files. The Health Board remains as the data controller for all patient information.

2.47 Achieving a balanced report is important to achieve a rounded understanding of the issues. However, the largest section of this review relates to the experiences of women and families who use these services.

Balance of Report

Key: Distribution of findings

	Topic under review
	Experience
	Detailed clinical review
	Governance
	Staff
	Data and analysis

2.48 All of the information used as part of this review will be safely destroyed by Niche two years after the point that it is archived or at two years after the point of last contact in relation to this review.

Can women and families have confidence in these services today?

2.49 We recognise that this will be the most pressing issue on the mind of any woman (or family member) who is pregnant or about to give birth or wants to use SBUHB's maternity and neonatal services in the future. They will want to know that the services that they are accessing are **safe**, **kind** and **reliable**.

2.50 It is important to know that many women have an experience of pregnancy and birth which is, at its heart, seen as satisfactory and within that, some women will describe their birth experiences at SBUHB as good. This report places a lot of focus upon the women and families who feel they did not have a good experience, and it is vital to hear their views and to learn from their experiences.

2.51 This report will describe that experience is dependent upon so many things, as indeed, are 'outcomes' of pregnancy. Pregnancy is a relatively long journey of patient care and of patient experience (usually women are in touch with services for an intensive seven or eight months). That means there are many interventions and contacts along that journey. Some clinics will be busier, some less so. Occasionally staff on a unit might be managing a high-risk birth or sudden increase in attendances, but this should not in turn mean that any woman's care is compromised. However, it might sometimes mean that they may not have the experience they wanted, and a woman might not get continuity of carer or the birth they had expected.

2.52 From our work on this review and in the learning from other reviews, including the recent Llais review, we know that the important questions asked by women and families are:

Safety for mother and baby

2.53 From all of the detailed clinical reviews (between 2019 and 2022) undertaken for this review, the vast majority concluded that clinical care was provided in line with expected clinical practice. This means that, even when things did not go to plan (pregnancy and birth can be unpredictable), that the way the care team responded to those situations was usually clinically appropriate, with some exceptions which are discussed in this report.

2.54 The Health Board has introduced some safety enhancements which are detailed in this report, and those include:

- Introducing Maternity Early Warnings Scores (MEWS) to better identify pregnancy risks and to support early intervention.
- Ensuring that additional ultrasound scanning (every three weeks) is available to support the monitoring of risk.
- More staff have been recruited so there are less vacant posts and staffing levels are in line with expected safe staffing standards. Staff sickness rates are higher in the maternity service than the neonatal service, but this is, over time, coming down.
- In April 2025, the majority of maternity and neonatal staff were up to date with their training needs. Compliance with mandatory training requirements ranged between 85-93% across staff groups; the Welsh Government target is 85%.
- The Health Board is continuing to work on improving its system of triage (this can be compared to an Accident and Emergency (A&E) department for maternity services).

What do the latest outcomes and performance suggest?

2.55 Antenatal computerised cardiotocography (CTG) monitoring is now a widely used tool for fetal assessment in the antenatal period within the UK and can be very important in the

detection of issues which may lead to problems at birth. Most local guidelines recommend its use for all babies requiring a CTG in the antenatal period. However, antepartum CTG interpretation by staff has been identified as a significant root cause of stillbirth and serious brain injury[11].

2.56 All maternity staff are now subject to the annual All Wales education programme for the interpretation of CTG fetal heart tracings and access to computerised CTG analysis has now increased.

2.57 The service has also secured funding to upgrade the CTG software capability to ensure this is readily available to support clinicians in the analysis of CTGs and to ensure prompt and timely escalation for abnormal tracings.

2.58 Maternity services have now implemented serial ultrasound scans of all pregnant women who smoked at conception since January 2023; three-weekly scanning for women at high risk of small for gestational age babies was also implemented.

2.59 Up-to-date analysis from MBRRACE-UK is not yet available, however, the crude (unadjusted) national stillbirth rate for 2024 is showing a gradual downward trend. UK-wide data from MBRRACE-UK reports covering 2018 to 2023 showed that stillbirth rates by ethnicity decreased in all groups after a rise in 2021, but wide ethnic inequalities remain[12]. MBRRACE-UK also highlighted in its report on perinatal mortality in 2023 that across the UK, babies of Black ethnicity are still more than twice as likely to be stillborn than babies of White ethnicity.[13]

2.60 Most of the stillbirths observed very recently (2025) were in the third trimester of pregnancy but most of the babies were classed as preterm births from mothers with risk indicators present. All received care in line with NICE (National Institute for Health and Care Excellence) quality standards although continuity of carer does remain an issue.

2.61 Following the rise in cases of hypoxic-ischemic encephalopathy (HIE) in 2023 and early 2024 HIE rates have now reduced significantly. More detailed analysis is being done, and insight is now greater although there is still more to do to put that learning into direct and sustained practice.

Accessing services when you need them.

2.62 The Health Board has made improvements in the way that people can access services and the choices that they have about the kind of birth that they want. For example, the home birth service was restarted in October 2024 and the midwifery-led birth centre at Neath Port Talbot Hospital was also re-opened in September 2024. Services being located on different sites is a risk which requires increased attention by the Health Board.

2.63 Women whose first language is not English have particular concerns about how, when they do access services, they are able to communicate with staff in a safe and effective way, and this can introduce risk. The Health Board is currently piloting an All Wales NHS Fast Track language service for women with no or limited spoken or understood English.

2.64 The Health Board is continuing to work on improving its system of triage. Not all triage is accessed through a single process, and this creates some additional risks. The operating model for triage now includes mainly dedicated core midwives who only work in triage. This ensures that there is consistent in-depth expertise on hand for women in an emergency scenario.

2.65 If labour needs to be induced, then there are some risks that this may be paused or stopped or restarted. The Health Board are trying hard to minimise this because they know that it is stressful for women. More information about induction is being developed and the Health

Board is contributing to All Wales approaches around this. Induction rates have remained relatively stable over the last four years and are falling below the national average.

2.66 There are some risks associated with delayed transfers from the freestanding midwifery unit (FMU) or home birth into hospital-based care. The Health Board is working to better coordinate this critical access point through triage and with the Welsh Ambulance Service.

Access to pain relief

2.67 Women need to know that if they want an epidural that it will be available to them as well as other forms of pain relief, such as gas and air. Anaesthetic cover must be set at appropriate levels so that women can usually access pain relief when they need it. The Health Board has also taken the following steps:

- Introduction of Self Administration of Medication – this is pain relief which is controlled by the woman as and when she needs it.
- More regular medication and observation rounds have been introduced to improve access to medication and more drug trolleys have been made available.
- Choice of type and place of birth has become much more available through home births and midwife-led births with access to a birthing pool.
- Delays in induction of labour are also being managed as a key risk and there is more focus on avoiding this.

Kindness and compassion

2.68 The Health Board has recognised that it has not always been kind and compassionate to women and families, particularly when things have gone wrong and people want to raise concerns. This needs to change at both a local level with the Health Board and on an All Wales basis, with new approaches to 'Putting Things Right' (these are the Welsh standards for handling concerns and complaints). Other key developments include:

- The new Swansea Bay Maternity Services Charter openly commits to how the Health Board will treat people with compassion and care.
- Access to the debrief process has increased with the recruitment of a dedicated midwife in this area and in addition, debriefs are now working more with families' timescales rather than the service's timescales.
- All nurses and midwives will receive specialist bereavement training. We also suggest that the same cohort of staff, plus staff working in complaints, should receive specialist training in trauma.
- All families who have experienced a stillbirth or neonatal death will be invited to contribute to and receive a written account of the mortality review process and will be advised of the timelines for the final review report. There will also now be a named contact from the governance team, along with details of how to contact the team, should they have any questions regarding their review.
- Response times for complaints are reducing although more work needs to be done in terms of the compassion shown in these responses.
- A Maternity Services Patient Experience Forum has been established. Maternity Voices Partnership (MVP) is also planning neonatal and postnatal '15 steps'[14] visits.
- There is a plan to recruit a full-time Women's Experience Midwife. Since April 2025, the Health Board has started issuing surveys to all people using maternity services throughout their pregnancy and following birth.

- A ‘Dads and birthing partners survey’ is also now running to enable the MVP to gain insights around these experiences.

Access to information and support

2.69 The Health Board needs to do more work on whether women and families feel that information is appropriate for their needs. However, more written information is being provided, and work is being undertaken, alongside the MVP, to ensure that the information is accessible and provides the right sort of advice.

2.70 Additionally, more work needs to be done to work with women around expectations of pregnancy and whether they might be more likely to feel or experience trauma, so that plans can be put in place to provide early psychological support where this is needed. Other work includes:

- Increasing support for breastfeeding with continuation of training for staff to UNICEF UK Baby Friendly Initiative[15] standards, increased midwifery resource for this purpose and the introduction of additional support groups. Llais has indicated in its report of May 2025 that early breastmilk use has increased from 47% to 71%, which is the best rate in Wales.
- Having enough staff on shifts and making sure that sickness and absence are covered will release staff time to support women, focussing on ensuring a woman is always placed at the centre of her care.
- The MVP is developing an ‘Ask Us’ campaign/strategy, so the slogan ‘Ask Us’ would be visible across all of maternity services.
- Ensuring that women are involved in decisions about their care needs to run throughout all aspects of maternity and neonatal services. This requires a cultural shift and awareness, more access to information, more access to choice and a focus from staff on informed consent[16].

2.71 Women feel more vulnerable when they cannot make an informed choice, even in urgent situations, and this is rooted in a fundamental principle of healthcare law. Risks must be properly explained to women and their families and there must be recognition that women may need to have several conversations, or they may need information which is delivered in a different way[17].

2.72 Most of all, women need to be shown compassionate understanding when asking questions, to not feel like they are seen as an inconvenience, and to not have to repeat information. The Health Board is still on a journey in this respect.

3

3. The context affecting the provision of maternity and neonatal services

Summary

The challenges facing the Swansea Bay University Health Board (SBUHB) can only be properly understood and assessed by recognising the health and social context in which it is seeking to provide services. This chapter sets out some of the key contextual information.

Note: The catchment area covered by SBUHB includes the local authority areas of Swansea (City and County), Neath Port Talbot and parts of Carmarthenshire, Powys and Bridgend; we refer to this as Swansea Bay throughout our report. The analysis of data provided by SBUHB captures all deliveries to women resident in these areas. Where references are made official population data, this covers the local authority areas of Swansea and Neath Port Talbot.

Overview

- This section explores the core context of maternity services at SBUHB, factoring in differences in population characteristics across England and Wales; this can influence risk factors and outcomes of pregnancy. When those risk factors are understood and adjusted properly into care activities, the instance of harms which occur should be reduced. However, this is not the case in England and Wales and outcomes are still variable.
- Several high-profile reports into maternity services (in England and Wales) have provided an extensive number of recommendations arising from a range of different themes which are broadly consistent across these reviews. The issues with maternity and neonatal services are by now, well known. Several ambitions for maternity safety have now been set out in Wales in the Quality Statement for Maternity and Neonatal Services (2025).
- Like most cities and localities in England and Wales, SBUHB serves people across a range of income, deprivation, education, age, religion, and ethnic backgrounds. There are significant levels of deprivation in the Swansea Bay area, and over the last five to six years, MBRRACE-UK data indicates that a higher proportion of women from deprived areas gave birth at SBUHB, than in other areas of the UK.
- Swansea and Neath Port Talbot have a significantly lower proportion of non-White ethnic groups than is typical across the UK. The female population of child-bearing age is predominantly White but there is a higher proportion (8.9%) from non-White ethnic groups than is typical across Wales (excluding Cardiff). The largest non-White broad ethnic minority group is South Asian (over 4%); Black women represented 1% of this population cohort with other and mixed ethnicities accounting for 3%.

Births and perinatal outcomes

- In 2024, there were 3,277 deliveries (3,300 in 2023) reported by SBUHB. There was over a 6% fall in the number of deliveries over the five-year period from 2019 to 2024.
- MBRRACE-UK data indicates that, when viewed together for stillbirths and neonatal deaths, SBUHB was an outlier for three consecutive years between 2019 and 2021, and then also in 2023. In 2018 and 2022, the Health Board's rates were similar to, or lower than, the average for similar organisations.
- There was a significant increase in the number of moderate to severe HIE cases in 2023 and 2024 (15 cases). There are no national benchmarks to compare the rate of the number of HIE cases, however, the Health Board undertook benchmarking using the

National Neonatal Research Database which showed that the current rate of HIE is comparable to benchmark levels.

- Our review found that that there are some factors (as illustrated below) which might increase the risk of poor pregnancy outcomes for SBUHB. Outcomes are presented in the reports by MBBRACE-UK which provide stabilised and adjusted mortality rates (accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and, for neonatal deaths only, gestational age at birth) which adjust for differences in case mix when comparing outcomes between organisations. We found significant features for SBUHB to consider including:
  - Since 2018, SBUHB has consistently been highlighted in MBRRACE-UK reports as having a higher proportion of mothers under the age of 25 than for the UK as a whole; in 2023, this was just over 17% for SBUHB compared to 14% for the UK.
  - Smoking levels at booking for SBUHB were significantly lower at 11.4% than for Wales overall (14%) however remained higher than in England (9.6%).
  - At SBUHB, 40.2% of women reported a mental health condition at initial assessment, compared to 31.6% for Wales overall; this was the highest reported percentage across all Health Boards in Wales.
  - The ONS Crime Survey[18] for the year ending March 2024 reported that in Wales, almost 10% of women (aged 16 and over) were victims of domestic abuse compared to 6.5% of women across England and Wales.

Between January 2019 and March 2024:

- Labour was induced for almost 29% of all deliveries in 2023; however, induction rates have not varied significantly over the five-year timescale. SBUHB's induction of labour rate in 2023 compared to 35% for Wales overall and was the lowest reported percentage for all Health Boards in Wales. Our analysis showed that mothers from the more deprived areas of Swansea Bay were more likely to have labour induced.
- For SBUHB, almost one in nine babies (11%) were born weighing less than 2500g. For Wales overall, 2023 data indicated that 7% of newborns were affected by a low birth weight. SBUHB's latest data for 2024 (Enhanced Monitoring report, March 2025) indicated that over half of babies who were stillborn were found to have a birthweight below the 10th centile. Mothers from the more deprived areas of Swansea Bay were more likely to have a baby with a low birth weight.
- There was a greater proportion of babies born prematurely at SBUHB compared to the UK average. Mothers from less deprived areas of Swansea Bay were less likely to have a premature baby.
- Since 2015, stillbirth rates have been consistently and significantly higher for mothers from the most deprived areas of Wales. This is a particular challenge for SBUHB as over the last five to six years, almost a third of deliveries were to women from areas classified as amongst the most deprived areas in Wales.
- There has been an overall reduction in the rate of both obstetric haemorrhage and third or fourth-degree tears. Mothers from less deprived areas were more likely to have an obstetric haemorrhage or third or fourth-degree tear.
- Analysis from January 2019 to June 2024 for SBUHB generally showed a significant reduction in continuity of care for mothers as the maternity pathway progresses.
- Activity levels in terms of admissions have been relatively static over the period; this could be an indication of increased acuity as the number of deliveries has fallen.

Admissions to the Neath Port Talbot Birth Centre were on a decreasing trajectory before its temporary closure in September 2021. SBUHB do not collect data on activity for community midwifery teams.

- Analysis of ward activity and capacity showed some challenges in terms of demand for beds across many ward areas; this was a particular issue on the labour ward and postnatal wards in 2023/24. Positively, for the neonatal unit, there were no occasions of demand for cots exceeding capacity in 2023 or in the first six months of 2024.

The current landscape of maternity services in England and Wales

3.1 Despite significant improvements over the years, in safety and the management of risk, a positive outcome for all pregnancies cannot be guaranteed. This can be as the result of natural causes such as miscarriage and stillbirth (between 25 and 30% of all conceptions in the UK will not result in a live baby because of natural causes and genetic conditions).

3.2 Causes which relate to maternal health such as poverty, nutrition, immunisations, substance abuse and accidents may occur. Other factors which result in poor outcomes can be the result of the care provided by health services themselves and those factors are the primary focus of this review. Those factors can be seen as 'modifiable' and, if addressed in a systemic way, should result in sustained improvement.

3.3 In the last ten years, many aspects of maternity care in the UK have become safer and because of this, neonatal mortality rates have been steadily decreasing. However:

- Around 13 babies still die shortly before, during or soon after birth every day across the four nations of the United Kingdom (12.8 deaths per 100,000 women).
- Since 2015, the number of deliveries has been steadily declining across England and Wales; in 2023 there were 563,561 live births. In Wales specifically there were 27,374 live births, the lowest number since broadly comparable records began in 1929, marking a decline from the previous year and a 23.2% decrease compared to 10 years ago.
- The number of births per midwife has also been dropping, and the average number of midwives nationally (England and Wales) has generally increased in the same timescale.
- Approximately 30% of babies born in the UK are to women of non-White ethnicity. Stillbirths and neonatal deaths remain higher among ethnic minority groups.[19] Stillbirth rates for Asian ethnic groups increased in 2023, compared to 2022 across the UK.
- MBRRACE-UK data for 2020-2022[20] indicated an almost three-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds compared to White women. In addition, there remains an almost two-fold difference in maternal mortality rates between women from an Asian ethnic background compared to White women. Women living in the most deprived areas of the UK have a maternal mortality rate more than twice as high as women living in the least deprived areas.
- Data from 2022/23 shows that over 800 babies across the UK might have been saved with better care in that year alone[21].
- As many as 15% of total birth injuries across the UK may have been the result of negligence and unnecessary errors[22].
- Claims for birth injury are substantially on the rise across the UK (although in England the claims are now being alerted much more quickly under the Early Notification Scheme (ENS) which may account for some of that rise).

Maternity Safety Ambitions

3.4 According to NHS Resolution, who operate the NHS Early Notification Scheme, the most common birth injury which leads to a significant claim is brain damage (intrauterine hypoxia, also known as fetal hypoxia) caused by oxygen deprivation. Fetal hypoxia occurred during 7.5% of all births in 2021/22 in the UK, however, this can be treated rapidly and to good effect by 'cooling' the baby.

3.5 Evidence indicates that the primary causes of fetal hypoxia are clinical negligence and unnecessary errors, failing to treat or delaying treatment and failing to monitor in the second stage of labour. This is, on the surface, indicative of a lack of due care and attention, but there is a significant requirement to look beneath the outcomes to understand why these issues continue to occur nationally, and how these statistics relate specifically to maternity and neonatal care provided by SBUHB.

3.6 The National Maternity Safety Ambition (England) includes targets (table below), using a 2010 baseline, to halve the rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies by 2025, with a 20% reduction by 2020. The table below shows progress up to 2020 against these targets. Rates of neonatal and maternal deaths and brain injuries did not meet the 20% target reduction by 2020 and appear unlikely to halve by 2025:

National Maternity Safety Ambition Targets	2010	2020	% change	Likely to achieve target?
Stillbirths per 1,000 live births	5.10	3.80*	-25%	No
Neonatal deaths per 1,000 live births	2.90	2.70	-7%	No
Maternal deaths per 100,000 maternities	10.60	11.70	+10%	No
Brain injuries per 1,000 live births	4.14	4.07	-2%	No

**This metric has since increased to 3.9%.*

3.7 The ability to ensure that safety improvements are sustained is critical, but change is slow and, in some cases, not sustained. When modifiable factors are properly addressed, harm is reduced, and women and babies have better birth outcomes. However, improvements in safety systems are still not being implemented and avoidable harm is still occurring.

Reports which have already highlighted these issues

3.8 Major reports into maternity care in England, Northern Ireland and Wales in the last five years have included:

- *Review of Maternity Services at Cwm Taf Morgannwg Health Board (Panel, 2022)*
- *Independent Review of Maternity Care at The Shrewsbury and Telford Hospitals (Ockenden, 2022)*
- *Maternity and Neonatal services at East Kent (Kirkup, 2023)*
- *Enabling Safe Quality Midwifery Services and Care in Northern Ireland (Renfrew, 2024)*
- *The UK Birth Trauma Report to Parliament (2024)*

3.9 All reports have provided an extensive number of recommendations arising from a range of different themes which are broadly consistent across reviews:

- Women frequently feel discounted in their care; sometimes care is said to be dehumanising, and women experience a loss of power and agency. Often, they report

being treated without compassion and this leaves them feeling scared and far too frequently, traumatised.

- Families can be harmed by poor care which lacks compassion. Not only can the harms caused by poor care be life-changing for the family and the child, but the emotional impacts on both the mother and birth partner can frequently become a *disease burden* in themselves. Other children in the family can suffer vicarious harms from poor maternity and neonatal care.
- The risk profile of women giving birth is increasing in some areas. Women can give birth later, lifestyle factors may create ill health, and women may present to maternity services at a later stage when they are in subsequent pregnancies. The Royal College of Midwives also says: "the midwifery workforce has not kept up with higher demands due to an increasing proportion of pregnancies and births for women who have medical and social needs, combined with government policies to provide women with more personalised care and greater continuity of care."[23].
- Staff are not always able to deliver the care that they are trained for and want to provide, and safe staffing is cited as an issue in almost all reviews. Staff are frequently adjusting the way they work to manage patient flow, activity and acuity through the department.
- Monitoring, escalation and rapid intervention are not where they should be. Boards are often not sufficiently aware of issues in maternity, and staff on wards are not getting sufficient access to the information that they need to provide them with insight on how their services are performing.
- There is insufficient scrutiny applied when things go wrong. Investigations are of poor quality, women and families do not get the early and compassionate answers they seek, organisations can easily look evasive, and the whole system fails to learn and improve. The trauma experienced when things go wrong can easily become *compounded* by the organisation's handling of concerns and incidents, particularly around bereavement care and trauma support.

3.10 The weight of evidence suggests that maternity services are struggling to ensure that change occurs from the issues which are highlighted to them. Women experience similar issues during pregnancy and birth in many areas of the UK and the issues are known because they have been repeatedly surfaced. This indicates that the countless recommendations which ask organisations to 'listen' to women and families are either, not being understood, not being implemented, or the recommendation itself is not sufficiently targeted towards promoting the necessary systemic change.

3.11 The recent Quality Statement for Maternity and Neonatal Services (Wales) Feb 2025 provides several ambitions for services to achieve. Each Health Board has been asked to adopt the Quality Statement as a framework for enabling optimal care in perinatal settings; the ambitions include:

Safe

- Consistent use of person-centred, evidence-based pathways of care, delivered by a skilled multiprofessional workforce, supported by robust clinical governance arrangements and escalation pathways from ward to Board.
- Risk held within the service is systematically assessed, communicated and escalated within the organisation as well as through national governance systems, with appropriate measures taken to proactively reduce the potential for harm.

- Systematic monitoring of demand and capacity information to inform service design and configuration, with consideration of acuity, complexity and specialist requirements to enable delivery in line with agreed national standards and recommended staffing ratios.

Timely

- Systems and processes are in place for effective multiprofessional and multiagency communication across perinatal services to deliver care in the most appropriate place and time.
- Timely, robust and evidence-based assessment is undertaken for all aspects of perinatal care in line with agreed protocols, overseen by skilled and experienced professionals to enable effective decision making and clinical prioritisation.

Effective

- Universal care pathways are autonomously provided by midwives to ensure a holistic approach to care, with additionality depending on the level of complexity. Women receive dedicated support from the same midwifery team throughout their pregnancy in line with the continuity of carer model.
- Standardised reporting and multiprofessional perinatal investigation for adverse events is undertaken, with effective local and national processes in place to share learning, implement changes and reduce the risk of future harm. Openness and transparency are demonstrated in line with the statutory Duty of Candour and women, parents, and families are involved throughout the investigation process.
- Robust population health strategies are in place to promote health and wellbeing with a focus on prevention, supported by processes for providing guidance, advice and support. There are effective mechanisms for capturing, monitoring and evaluating population health data to inform quality improvement initiatives.

Efficient

- Available resources are used efficiently and sustainably with a view to minimising environmental impact, whilst maintaining a clear focus on delivering person-centred care to maximise outcomes and experiences.

Equitable

- Care and treatment are determined by clinical priority and delivered in an equitable way, understanding any additional care needs, with a clear focus on avoiding unnecessary variation and intervention.

Person centred

- Appropriate and timely information is provided in multiple languages and formats, and women are supported to make informed decisions throughout their pregnancy, birth planning, birth and the postnatal period. A range of birth settings are available including hospital, birth centre and home birth.
- Healthcare professionals respect and support the autonomy of women as decision-makers regarding their own care, and ensure they are made aware of their rights around consent[24].
- Unnecessary separation of mothers and babies should be avoided with transitional care provision consistently available.

- Parents are supported and empowered to be primary care givers and viewed as equal partners in all aspects of their baby's care. A family integrated care model will be facilitated whilst babies are on the neonatal unit.

3.12 We have used this framework to test out the current service provision and to support the Health Board in identifying gaps. In using this Framework as a primary assessment tool, the Health Board can continue to 'self-assess' in the most relevant way going forward. This assessment is contained in full within the appendix.

Understanding the demographic context in Swansea Bay

3.13 To fully understand how services are meeting the needs of the local population and the extent to which they compare to other similar services, it is vital to understand the demographic context surrounding the services. Understanding the local health factors helps maternity services to cater to demand and capacity, staffing and risk.

3.14 There are distinct risks during pregnancy relating to socio-economic factors, ethnic variation and geographic rurality. These issues need to be considered when planning maternity care locally as issues such as levels of deprivation, distance from hospital services, ethnicity and cultural preferences can impact on maternal and fetal health and have been observed to feature in the causes of perinatal mortality and poor outcomes. In Wales Health Boards have an accountable duty around health inequalities[25] and population wellbeing[26].

3.15 To support women and families from different socio-economic backgrounds the Health Board set up an early intervention service called Jig-So three years ago which has a team of predominantly midwives but also nursery nurses and speech and language therapists. Initially, the initiative was for young expectant parents aged 16-24 but was expanded around 18 months ago to include anyone who may need additional support. Women who might benefit from the service are identified at booking and referred, or they can be referred by a social worker who may already be in contact with the family. In early 2025, there was reference to seeking additional capacity for this service.

3.16 Most of the detailed and extensive demographic analysis for this review is contained within the appendix and fundamental context is distributed within the report pages. This section provides a brief overview of the demographic context for SBUHB, where we reviewed:

- population data (from the 2021 population census and Welsh Index of Multiple Deprivation (WIMD) 2019) and epidemiological research into the potential specific risk factors for the local population;
- episodic activity data for maternity services over the three years to understand the operating context for the department and any significant changes in key performance metrics (number of deliveries, demand, mortality, length of stay);
- bed capacity data for maternity and neonatal wards, theatre capacity, staffing data, shift fill rates; and
- data provided in the MBRRACE-UK reports.

Geography

3.17 SBUHB covers a population of around 390,000 in the Neath Port Talbot and Swansea areas, as well as providing some specialist services to neighbouring areas. The catchment area covered by SBUHB includes the local authority areas of Swansea (City and County), Neath Port Talbot and parts of Carmarthenshire, Powys and Bridgend. Swansea County itself has

many rural areas with significant travel times to hospital-based services and therefore to antenatal checks and ultrasound scans.

3.18 Analysis of SBUHB data from January 2019 to March 2024 by local authority area shows that almost 60% of births were for women living in the Swansea local authority area, 28.5% Neath Port Talbot and 7.9% for mothers living in Carmarthenshire.

Local geographical distribution

Key:

%	Location
60%	Swansea
28.5%	Neath Port Talbot
7.9%	Carmarthenshire
3.6%	Other

Deprivation

3.19 Deprivation can have a significant impact on maternal and fetal health and associated pregnancy outcomes. Stillbirth rates have been higher for mothers' resident in the most deprived areas consistently since 2015[27]. Understanding local area deprivation and the circumstances of parents is pivotal to providing appropriate care and support to mothers, babies and families, both antenatally and postnatally.

3.20 Like most cities and localities in England and Wales, SBUHB serves people across a range of income, deprivation, education, age, religion, and ethnic backgrounds. There are significant levels of deprivation in the Swansea Bay area, and over the last five to six years, MBRRACE-UK data indicates that a higher proportion of women from deprived areas gave birth at SBUHB, than in other areas of the UK.

3.21 The Welsh Index of Multiple Deprivation (WIMD) report of 2019 details indicators for deprivation covering income, employment, health, education, housing, access to services, community safety and the physical environment and shows:

- The majority of communities across the Swansea Bay area are affected by deprivation (60-70% of homes overall).
- With the exception of the 2023 report, since 2018, SBUHB has consistently been highlighted in MBRRACE-UK reports as having mothers who were considerably more likely to live in areas of high deprivation than those giving birth across the UK as a whole.

Ethnicity

3.22 Risk factors in pregnancy are more prevalent for women from ethnic minority groups from a maternal physical and mental health perspective. Health risks for these women and babies can be compounded by socio-economic deprivation, language barriers and maternal behaviours due to cultural norms, which may affect access to services and support.

3.23 For Swansea and Neath Port Talbot, the female population of child-bearing age is predominantly White but there is a higher proportion (8.9%) from non-White ethnic groups

than is typical across Wales (excluding Cardiff). The largest non-White broad ethnic minority group is Asian which includes women of Bangladeshi, Indian, Chinese and Pakistani origin. South Asian women are 60% more likely to suffer stillbirth or a neonatal death, and their babies are much more likely to be born preterm. Black women (African and Caribbean) accounted for almost 2% of the female population.

3.24 Analysis of the cases reviewed by the clinical review team showed that 84% of women (148) were from a White background and 5% (9) were from an Asian background. No ethnicity information was available for 11% (20) of the cases). MBRRACE-UK data indicated that White women represented 53% of deliveries over the five years to March 2024; however, this analysis was unreliable as almost half of deliveries did not have this characteristic recorded.

Risk factors in pregnancy

3.25 There are specific risks to maternal and fetal health which can be compounded by socio-economic deprivation and ethnicity factors.[28] Most notably:

- The risk of stillbirth, neonatal death and preterm birth increases with socio-economic deprivation. Households with the lowest income, most overcrowding and highest unemployment are typically Black African, Pakistani, and Bangladeshi.
- South Asian women are 60% more likely to suffer stillbirth or neonatal death, and their babies are much more likely to be born preterm.[29] [30]
- Black women are over twice as likely to have a stillbirth, and neonatal mortality is 43% higher compared to White women.[31]
- Most stillbirths are attributed to placental or neonatal causes but for at least one third, no causative factors are identified.

3.26 Explanations for socio-economic and ethnic variations in the causes of stillbirth and neonatal mortality involve multiple physiological, psychological, environmental and socio-cultural factors. We set out below the key issues that need to be considered when planning care for women locally.

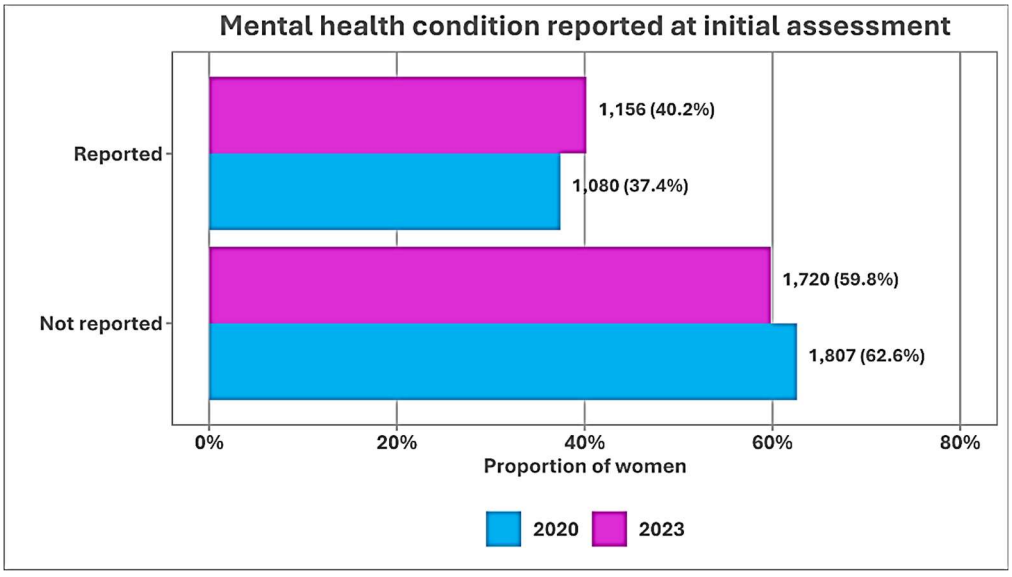
Maternal Health

3.27 There is substantial evidence of factors relating to maternal health that can impact pregnancy outcomes; these are summarised below but covered in more detail within the appendices:

- **Physical health conditions** - Hypertension and diabetes contribute significantly to poor pregnancy outcomes. Factors such as smoking, obesity and drug/alcohol abuse are common in socio-economically deprived areas. Public Health information (latest data available for 2023) showed that SBUHB had 31.5% of women reporting a body mass index (BMI) of 30 or higher at initial assessment, compared to 31.9% for Wales. A person with a BMI of 30 or greater is considered obese. The equivalent figure for England in 2023/4 was 26.2%.[32]
- **Maternal age** - Women aged under 20 or over 35 have increased risk of poor pregnancy outcomes. Since 2018, SBUHB has consistently been highlighted in MBRRACE-UK reports[33] as having a higher proportion of mothers under the age of 25 than for the UK as a whole; in 2023, this was just over 17% for SBUHB compared to 14% for the UK.
- **Maternal behaviours** - Smoking, drug/alcohol abuse and poor diet are well known risk factors and are associated with socio-economic deprivation, particularly in White British populations. Smoking during pregnancy increases the risk of stillbirth,

miscarriage and preterm birth. 2023 data for smoking incidence at booking appointment indicated that for SBUHB a lower proportion of women were smokers at booking appointment than in Wales overall; however, smoking levels at booking were significantly higher for SBUHB (11.4%) than in England (9.6%).

- **Interaction with maternity services/language barriers/cultural issues** - Deprivation and cultural issues can lead to barriers to accessing maternity care both antenatally and postnatally, and this is associated with higher rates of complications. Maternity data for Wales showed that for SBUHB in 2023, 74% of women had an initial assessment carried out by 10 completed weeks of pregnancy, compared to 76.6% for Wales overall. However, in 11% of cases, gestational age at booking was not recorded at SBUHB.
- **Ethnic background -** Black and South Asian women tend to start engagement with services later in pregnancy and have fewer antenatal checks and ultrasound scans.[34] These factors can influence whether women regularly attend antenatal clinics, understand the reasons for antenatal care, and understand the pregnancy related information they are given.
- **Maternal mental health** - Poor maternal mental health, including depression and anxiety, often exacerbated by socio-economic challenges is linked to poor pregnancy outcomes. Women with mental health disorders are likely to have less frequent antenatal care and make poor lifestyle choices. At SBUHB in 2023, 40.2% of women reported a mental health condition at initial assessment compared to 31.6% for Wales overall; this was the highest reported percentage across all Health Boards in Wales[35]. The increase in reported mental health conditions for SBUHB since 2020 is shown in the diagram below:



3.28 NICE Clinical Guidance (CG192), Antenatal and postnatal mental health: clinical management and service guidance, identifies indicators for potential mental health problems in pregnancy that should be assessed. Many of these indicators are linked directly to socio-economic issues and include:

- a history of any mental health problem, including past or present treatment and family history of mental health problems;
- alcohol and/or drug misuse;

- the woman's attitude towards the pregnancy, including denial of pregnancy or a concealed pregnancy;
- the mother–baby relationship;
- social networks and quality of interpersonal relationships;
- living conditions and social isolation;
- housing, employment, economic and immigration status;
- domestic violence and abuse;
- other carer responsibilities;
- language barriers; and
- cultural considerations.

3.29 Between January 2019 and March 2024, mothers from less deprived areas using SBUHB services were less likely to have a premature baby. 6.7% of births before 37 weeks were to mothers in the 20% least deprived areas compared to an overall average of 8.7%. The MBRRACE-UK site-specific reports for SBUHB from 2018 to 2023 provide more detail and show that:

- there was a greater proportion of babies born prematurely at SBUHB compared to the UK average; at 24-27 weeks, the rate was 0.7% (UK average 0.4%) and at 28-31 weeks, the rate was 1.3% (UK average 0.8%); and
- there was a similar level of babies born post-term (after 42 weeks) at SBUHB (almost 3%) and for Wales overall (3% per ONS births data for 2023). This position has remained steady over the period. This is a higher rate than the UK average which was 1.7%.

Covid-19

3.30 Physiological changes that occur during pregnancy have a significant impact on the immune and respiratory systems and increase stress on cardiovascular function. Pregnant women are therefore at higher risk of experiencing severe Covid-19, particularly at the later stages of pregnancy.

3.31 Vaccination is recommended for all pregnant women. Vaccination during pregnancy is not associated with adverse pregnancy outcomes nor linked with a higher risk of preterm birth, a small for gestational age baby or stillbirth. For non-vaccinated women, Covid-19 infection can cause inflammation of the placenta. Maternal death due to Covid-19 infection occurs more commonly in women who are not fully vaccinated.

3.32 A recent study published in the Lancet[36,] highlighted that Covid-19 infection is a risk factor with a moderate association with postpartum haemorrhage.

3.33 There is some evidence that a genetic variant can cause an increased risk of respiratory failure from Covid-19. Research found that this variant was carried by more than 60% of individuals with South Asian ethnicity compared to 15% of European origin.

Activity and performance analysis – key data

3.34 Observations from analysis of the episodic activity and performance data for SBUHB's maternity services over the period from January 2019 to March 2024 are summarised below. The graphical analysis and tables underpinning these findings are contained in the appendix 7. It should be noted that we have placed reliance on the nationally reported data for deliveries from StatWales.

3.35 We noted some weaknesses in the timeliness of data reporting to MBBRACE-UK by SBUHB and on the completeness of data for cause of death for stillbirths, and ethnicity classification.

3.36 The key activity statistics are as follows:

- SBUHB data reported for 2024 shows that there were 3,277 deliveries. There were 217 fewer deliveries in 2024 compared to 2019, a reduction of 6.2% over the period.

Number of delivery episodes per year					
2019	**2020**	**2021**	**2022**	**2023**	**2024**
3,494	3,378	3,449	3,338	3,300	3,277

- Over the analysis period, there was an average of 274 deliveries per month. There has been a reduction of 6% in the rolling average number of delivery episodes over the period indicating a decreasing birth rate.
- Overall, 96% of deliveries over the period were at Singleton Hospital, with 4% of deliveries recorded at Neath Port Talbot Birth Centre (which was closed over the period from September 2021 until September 2024.) Home births represented 0.8% of deliveries over the period. A small number of births were recorded at other locations (for example, in transit or at a different hospital).
- Since 2015, stillbirth rates have been consistently and significantly higher for mothers from the most deprived areas of Wales. This is a particular challenge for SBUHB as, over the last five to six years, almost a third of deliveries were to women from areas classified as amongst the most deprived areas in Wales. In 2024, there were 13 stillbirths and 12 neonatal deaths.
- For neonatal deaths, there was no clear pattern with mortality rates relatively evenly spread across the gestational age ranges with 50% of deaths occurring at under 28 weeks.
- For the Neonatal Intensive Care Unit (NICU), there was an average of 39 admissions per month, and admissions were relatively constant over the period.

Method and complications of delivery

3.37 Observations on trends in the method of delivery over the period from January 2019 to March 2024 are set out below. The table showing a breakdown of modes of delivery over time is derived from SBUHB episodic data.

- Over 55% of women had a spontaneous delivery. The latest available data for 2023 from StatsWales[37] shows that for SBUHB 47.4% of women had a spontaneous delivery compared to 45.1% for Wales overall. For England, the comparable figure was 41.3% (MSDS 2022/23).
- Over a third (34.2%) of deliveries were by caesarean section; almost 18% required an emergency caesarean section. 2023 StatWales data showed that 23.8% of women had a caesarean section compared to 19.8% for Wales; this was the highest reported percentage for all Health Boards in Wales. For England, the comparator was 23.8%.
- In 2024, deliveries which required the use of either ventouse or forceps were just over 5% of deliveries (5.6% in 2023) and this has reduced from 7-8% in 2020 and 2021.

Breakdown of mode of delivery

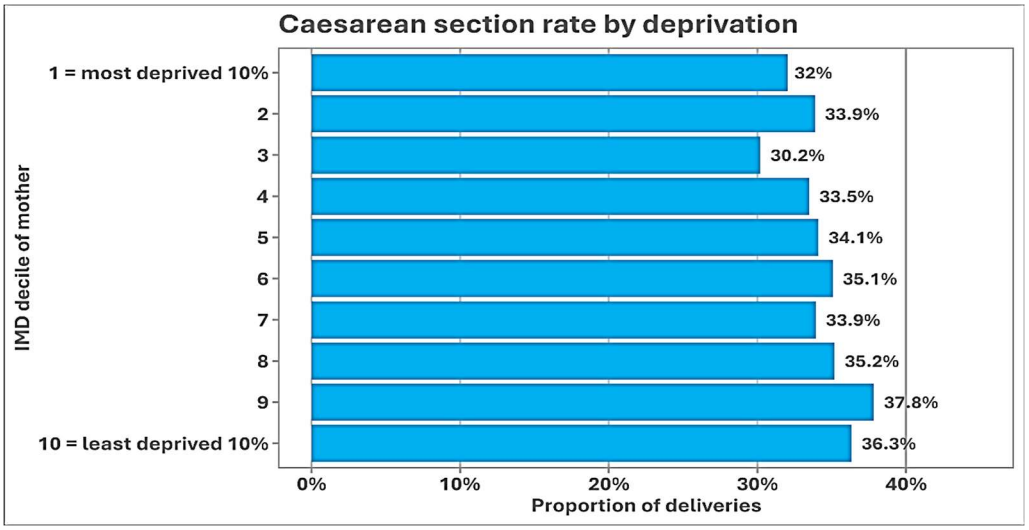
Delivery Method	Percentage of delivery episodes					
	2019	2020	2021	2022	2023	2024 (3 months)
Spontaneous	59.9%	56.3%	55.5%	51.7%	53.6%	51.3%
Emergency Caesarean	17.1%	17.0%	20.4%	22.2%	21.0%	23.1%
Elective Caesarean	12.1%	14.2%	14.2%	15.8%	16.2%	16.1%
Lift Out Forceps	5.5%	6.7%	4.8%	5.5%	4.5%	4.3%
Other Forceps	1.4%	1.5%	1.4%	1.6%	1.1%	0.8%

Caesarean section

3.38 The proportion of deliveries taking place by caesarean section (both elective and emergency) increased between 2019 and 2023/24 from 29.2% to 39.2% of all deliveries. In comparison, a decade ago in 2013/14, 26% were by caesarean section. There was a corresponding reduction in spontaneous (normal) deliveries from almost 60% to just over 51%. In Wales:

- Deliveries by emergency caesarean section have steadily increased over the period from around 17% in 2019/20 to just over 23% over the first three months of 2024.
- The rates of elective caesarean section have stabilised at around 16% of total deliveries over the period from 2022 to date, having increased from approximately 12% in 2019.

3.39 Our analysis of caesarean section rates linked to deprivation bandings showed that mothers from the less deprived areas were more likely to have a caesarean section. 37% of caesarean deliveries over the period were for mothers in least deprived areas of Wales, compared to almost a third of mothers living in the most deprived areas.



Induction of labour

3.40 Induction of labour (IOL) rates in the UK (and worldwide) are steadily increasing. In 2019 a third of women's labours were induced, with the rate for first time mothers as high as 36%[38]. IOL is undertaken for a variety of reasons including pre-eclampsia and post maturity. The evidence of the safety and effectiveness of IOL in improving outcomes has grown, although this evidence is disputed[39]. There are concerns that IOLs are becoming normalised and that the evidence used to underpin NICE guidance[40] is insufficient. Data on the implementation of NICE guidance is unreliable, in part because maternity departments each apply their own thresholds for IOL.

3.41 Making Birth Better[41] makes important links between induction and birth trauma themes and states that, "induction often reflects poor communication, scaremongering and being pressured" (amongst other key themes). This is discussed further in the next section of this review; however, our own research equally supports this view.

3.42 Welsh data (StatWales) for 2023[42] showed that for SBUHB, almost 29% of women had an induction of labour, compared to 35.2% for Wales; this was the lowest reported percentage for all Health Boards in Wales. For England, the comparator was 29.3%.

3.43 The following table shows the number of inductions of labour as a proportion of total births over the period from January 2019 to March 2024 (from SBUHB's episodic data).

Year	No. of deliveries	No. of inductions	% *(rounded)*
2019	3,494	947	27%
2020	3,378	1,050	31%
2021	3,449	996	28%
2022	3,338	1,022	31%
2023	3,300	934	28%
2024 (Jan-Mar)	750	234	31%
Total	**17,709**	**5,183**	**29%**

3.44 Labour was induced for 29% of deliveries overall between January 2019 and March 2024. The rate of induction as a proportion of births was variable but ranged from 27% to 31%. Induction rates have not varied significantly over this period.

Epidurals/pain relief

3.45 Studies have shown that epidurals[43], although not without risks, can reduce the risk of serious maternal complications during childbirth, such as severe postpartum haemorrhage. Low epidural rates can indicate potential challenges in access to pain relief or factors that may be hindering women from making informed choices about their labour. There is little evidence available to explain the significance of higher epidural rates in the NHS and more research is required.

3.46 16.4% of women using SBUHB services had an epidural compared to 25.7% for Wales; this was the second lowest reported percentage for all Health Boards in Wales. For England, the comparator was 26%.

Obstetric haemorrhage and perineal tears

3.47 Up to 9 in every 10 first time mothers who have a vaginal birth will experience some sort of tear, graze or episiotomy. There are different degrees of tear; a grade one tear is relatively minor, whereas grade 4 can extend to the anus and cause significant injury to the mother.

A perineal tear is more likely following a long second stage of labour, due to a large baby or an uncontrolled delivery of the baby's head; it is slightly less common for mothers who have had a previous vaginal birth.

3.48 For SBUHB, the proportion of delivery episodes recorded with an obstetric haemorrhage or a third or fourth-degree tear shows a spike in 2020, with 14% of all deliveries associated with one or more of these incidents. There has been an overall reduction in the rate of both obstetric haemorrhages and third or fourth-degree tears.

Incident type	2019	2020	2021	2022	2023	2024 (3 months)
Haemorrhage over 1.5 litres (%)	3.1%	3.8%	3.4%	2.9%	3.0%	2.7%
Rate per 1,000 deliveries	31.3	37.7	34.3	28.8	29.6	26.7
Third/fourth degree tear (%)	2.2%	3.0%	2.1%	1.9%	2.0%	2.4%
Rate per 1,000 deliveries	22.2	30.3	21.4	19.3	19.8	24.0

3.49 Mothers from less deprived areas were more likely to have an obstetric haemorrhage or third or fourth-degree tear. Just over 14% of deliveries with obstetric haemorrhage were to mothers in the 20% least deprived areas, compared to 10% of deliveries from mothers in the most deprived 20% of areas.

MBRRACE-UK

3.50 The MBRRACE-UK stabilised and adjusted mortality rates (accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and, for neonatal deaths only, gestational age at birth) are presented to account for differences in case mix when comparing between organisations and provide a more reliable estimate of the underlying mortality rate than using crude rates. SBUHB has been included in the comparator group with Level 3 NICUs.

3.51 For all years, the reports indicate that SBUHB was consistently meeting a reasonable level of data completeness in relation to the stillbirths and neonatal deaths and was not highlighted as an outlier against comparator organisations in this regard.

3.52 Over the period from 2018 to 2023, 90 stillbirths were reported to MBRRACE-UK with peaks of 20 in 2020 and 16 in 2023. Over the same timeframe, 45 neonatal deaths (a live born baby who died up to 28 days after birth) were reported with peaks of 12 in 2021and 9 in 2023. Further findings from the MBRRACE-UK reports for SBUHB for 2018 to 2023 are summarised below:

- The stillbirth rate increased from 2018 to 2020; SBUHB was highlighted as an outlier in 2020 (an adjusted mortality rate more than 5% higher than the average of similar Trusts and Health Boards). However, from 2021 to 2023, the stillbirth rate decreased and was comparable to other peer group organisations.
- SBUHB was an outlier on neonatal mortality rates in 2019, 2021 and 2023 (the Health Board's adjusted mortality rate was more than 5% higher than similar Trusts and Health Boards).
- When viewed together for stillbirths and neonatal deaths, SBUHB was an outlier for three consecutive years between 2019 and 2021, and then also in 2023. In 2018 and

2022, the Health Board's rates were similar to, or lower than, the average for comparator organisations.

- For 2021 and 2022 (data only provided by MBRRACE-UK since 2021), rates of perinatal mortality excluding deaths due to congenital abnormalities were similar to the average of peer comparators. However, SBUHB was an outlier in 2023 on stillbirths and neonatal deaths when congenital abnormalities were excluded.

Cases of hypoxic-ischaemic encephalopathy (HIE)

3.53 Hypoxic-ischaemic encephalopathy (HIE) is when a baby's supply of oxygen is interrupted during birth. Cooling treatment may be given if moderate or severe HIE is suspected. When diagnosed, HIE is graded as mild (stage 1), moderate (stage 2) or severe (stage 3).

3.54 As shown in the table below, data provided by SBUHB showed that there were 83 cases of HIE where the baby was cooled over the period from January 2019 to June 2024:

- Just over half of cases (42) occurred for babies who were 'outborn', i.e. born in other hospitals and transferred to NICU at Singleton Hospital for specialist care.
- 43% (36 cases) occurred for babies who were born at SBUHB ('inborn').
- In 5 cases, the baby was either born at home or in transit to hospital.

Grade	Inborn	Outborn	Home/in transit to hospital	Total
HIE Grade 1	4	11	1	16
HIE Grade 2	23	16	2	41
HIE Grade 3	9	15	2	26
Total	**36**	**42**	**5**	**83**

3.55 SBUHB provided some additional information on cases in a recent report (Oversight of quality and outcomes of moderate to severe HIE at SBUHB). A significant increase in moderate to severe HIE occurred in late 2023 to early 2024. In 2023, there were 10 inborn HIE Grade 2/3 cases (2.99/1000 live births); and in 2024, there were 5 HIE Grade 2/3 cases (1.8/1000 live births), so 15 of the 36 cases were for inborn babies. To date in 2025, there have been 3 Grade 2 HIEs reported.

3.56 Benchmarks are not available nationally to compare rates of moderate to severe HIE. In the report, SBUHB has undertaken some benchmarking with reference to the National Neonatal Research Database. For 2021 (latest published data), the benchmarking work highlighted the spike in 2023/24 (2.7/1000 live births) and states that current rate of HIE (1.6/1000 live births) is now at comparable benchmark levels.

4

4. The experiences of women and families

Summary

What are the key issues?

Whilst many women report a mostly positive experience of pregnancy and birth, some women have had and continue to have a poor experience. Some go further and describe examples of severe birth trauma. Whilst some of these predate 2024 / 2025, there are recent examples of similar concerns.

Our thematic review of over 1000 comments highlighted significant concerns with:

Communication and advice – Women having to repeatedly explain their medical history and past experiences, not knowing who their named midwife was or how to contact them, or how to raise any concerns.

Trauma and fear – Examples of unkind comments, and examples of how trauma and fear can be enduring and be shared, with birth partners feeling helpless and marginalised.

Feeling ignored – Examples of feeling dismissed and, at times, belittled in their interactions with triage staff; and a lack of information, follow up and feedback when something has gone wrong. This has left some families unsure of whether an investigation was going to happen, what any investigation had found, and whether there would be any learning or change to practice.

Compassion and care – Whilst some families were sympathetic to the pressures on NHS staff, some reported that the frustration of clinicians was sometimes very evident in how they were treated; and some women felt they were themselves being judged and blamed. Small acts of compassion are noticed and valued, but the impact is deep and enduring, where the woman has endured exchanges demonstrating a lack of empathy.

Informed decision making – Examples of women feeling insufficiently involved in decisions about their care and not being given or not understanding the information necessary for them to take proper decisions.

Access to care – Examples of barriers to families accessing the support they need. For example, while those who received bereavement counselling praised it, there was an apparent lack of capacity for such specialist support.

Birth partner and separation – Examples of birth partners not feeling included, and their attempts to advocate for their partners being unwelcomed. Some families reported being told that their partner could not stay because of the “rules”.

Additional concerns from seldom heard groups related to:

Language barriers and insufficient or ineffective measures to ensure that the family was understanding the treatment being provided, and any choices which might be available.

Cultural awareness, for example, about the wearing of a hijab, the importance of respecting women’s modesty, and about dietary practices and preferences.

What is currently in place?

A range of senior leadership appointments were made in 2024/25, which include a new Chair, Chief Executive, Executive Director of Nursing & Patient Experience and Clinical Director of Midwifery. Changes in leadership structures at a service group and directorate level including a new Clinical Director of Midwifery, Clinical Director of Obstetrics and Gynaecology, Associate Service Group Director and Associate Service Group Medical Director.

A Directorate of Insight, Communications and Engagement team (DICE) was established in 2022, which has provided willing and invaluable assistance to our review and represents a foundation from which to build. The DICE team seeks to ensure that feedback from families and communities is collated, understood and fed into the consideration of how services are delivered.

The Health Board works with the Maternity Voices Partnership and run a family and friends survey, but these do not currently represent the wider experiences of the women that have contributed to this review.

The Chief Executive has made two public statements which include acknowledgement of concerns, an unreserved apology to those who have experienced poor care, and a commitment to act to address concerns. These need to be underpinned by meaningful change throughout the organisation.

There are translation services in place, but these need to be reviewed in response to the feedback from families.

What is being progressed?

The Chair and the Chief Executive have met a small number of families affected to hear first-hand their experience and its impact. This needs to be continued.

What more is there to be done?

Far greater focus on delivery of compassionate care for all, with a commitment to take action where care and behaviours fall below acceptable standards.

The roll out for all staff of a compassionate care and increased cultural awareness programme.

Ensuring greater involvement of families in investigations.

Review of the complaints process, placing families at the centre.

The debrief service should be reviewed, to ensure improved access to the service as well as to ensure that all staff recognise their responsibility to respond to traumatic experiences.

Enhanced provision of timely access to psychological support and trauma-informed care.

An increased level of engagement with women, families and communities using the maternity and neonatal services locally.

SBUHB must now develop a new plan for improving the experience of women and families, addressing each of the seven themes listed above.

What are the immediate priorities?

- Delivery of compassionate and trauma-informed care is the top priority.
- Particularly urgent priorities are: improving the experience of families using the triage service; and making sure that families can trust the mechanisms for debrief and complaints and investigations when things have gone wrong.

Part 1 – the voices of women and families

4.1 This part of the review will put forward reflections on many different lived experiences of pregnancy and birth, all of which are important. Those testimonies are vital, and we are incredibly thankful to the families that took the time to share their experiences with us.

4.2 The Health Board serves a population of 390,000 and delivers around 3,300 babies each year, so we do not claim that our findings reflect every type of experience, however, we are confident that key themes have emerged. Feedback sitting outside of the key themes is also highly relevant and this has been used in part two, where we apply a deeper analysis to the relationship between themes, date ranges, areas of the pathway and other contributory factors.

4.3 All of the feedback used in this report has been analysed using a specific qualitative analysis tool (NVivo ™). All statements were assessed using data codes, pathway codes, care codes and a range of other codes. This helped the team to extract both a broad and deep understanding of themes, links between themes, the evolution of themes and the extraction of themes specific to these services.

4.4 In analysing the information, quotes and experiences in this way, we were able to examine 1,430 comments taken from our in-depth conversations, focus groups, surveys, the Llais report published in May 2025 and MVP feedback. We established seven main themes which arise a significant number of times across the feedback from women and families who had used SBUHB's services. These are set out below.

Theme no.	Topic:	The words covered within this theme:
1	Communication and advice	Kindness / rude / abrupt / hostile / caring / humiliated / no explanation / made a complaint / lack of answers / contact details given or not given / questions / answers / choice / options / understanding / planning.
2	Trauma and fear	Fearful / scared / upset / didn't understand / no answers / no explanation / mental health). Treated like meat / pulled / pushed / forced.
3	Feeling ignored	Neglected / worried / isolated / discounted / not a partner in care.
4	Compassion and care	Felt seen and heard / stayed with me / trusted / reassurance / disrespected / kindness / empathy.
5	Decision making	Not included / ignored / birth plan / did not agree / did not know / pressurised.
6	Access to care and services	Phoned the unit / sent home / ignored / not believed / no appointments / waiting times
7	Birth partner and separation	Alone / isolated / separated from / they were excluded / I needed them.

4.5 The following section is where the views and experiences of women and families are provided without interruption of analysis or commentary; this is in respect of their space and their voice. We have only arranged the raw feedback under the above themes. In Part 2 below, we analyse the feedback in more detail. Feedback has been anonymised although we have tried, in most cases, to keep the original wording used.

Raw feedback under the key themes:

Theme One – Communication and advice

4.6 "Because my baby was in NICU, I was really grateful, and care was really well managed, I did not think about it at first but afterwards everything was an absolute mess. This is why I needed a debrief and explanation of what happened as I genuinely do not know how they got from calm to chaos."

4.7 "There needs to be better coordination of care between the hospital setting and primary care and better communication following discharge from midwifery care. There also needs to be clarity about which service is supporting the new mother postpartum."

4.8 "It was stressful having to keep track of dates and medications to explain to every single doctor what had been happening as they often couldn't get all information on their systems. They didn't always read through my notes."

4.9 "I would like to note here that we have since learnt that it is common for pregnancies, where the baby presents in the back-to-back position in the womb, for contractions to be irregular well into labour. This is information that should have been known by everyone in the midwifery team in Singleton Hospital. As a result, I feel that the staff's ignorance needlessly endangered my wife and son."

4.10 B was scanned at 32+3 weeks and was told that she had a placental band: "I was not told what this was, but my sister googled it for me."

4.11 “The midwives in Cardiff provided very good clinical input and I had scans every 2 weeks. However, the information was not good at going between Cardiff and Swansea and I had to relay everything to the midwives in Swansea. It put a ton of pressure on me, on top of everything else. There were also many different consultants and lots of different opinions.”

4.12 “Afterwards I had a letter offering me a review. However, the debrief was with the same consultant who had spoken with me after the birth. I don’t feel that my questions were answered. I remembered everything and I had written it down.”

4.13 “You see different people every time as well. You’d go in and one would be very good. And they explain stuff and they’d be like, ‘oh, but this is what you need to do.’ And then you go in the next time speaking to a different consultant and you’d be like, but the last person told me this. And they’re like, ‘oh, yeah? Well, no, you don’t need that.’ Then they would dismiss their own colleague to do it their way. And then you’d be just left.”

4.14 “I could never get hold of her [midwife]. I’d leave a message but get no response.”

4.15 “The midwife I had been assigned was off work, but no one told me. So, when I rang her mobile and left a message, I just got no reply. I didn’t know what was happening.”

4.16 “I was given generic information such as eating and drinking, but nothing specific. If it’s your first child, you don’t know what to ask or what you need to know.”

4.17 “Inform women about all their birth choices, especially in labour ward where some people don't know they can have water birth or even use the pool.”

4.18 “Even though communication and FIC [Family Integrated Care] have improved so many things, at times the opportunity to ask questions may not always be there. There is still a lot of medical terminology to work through. Families still have questions, and it would be good to book an appointment in away from the unit to go through the things you want answered.”

4.19 “Midwife rang me to make appointment, and I had to tell her I'd miscarried, seems notes aren't even being updated correctly with miscarriages let alone births.”

4.20 “C and her partner felt that no one explained that having a stillbirth was a potential outcome of having pre-eclampsia. They knew it was serious but were not aware of how serious pre-eclampsia was. They have since done some research on it but at the time and being a first-time mum they were not aware of all the potential problems. They felt that the doctors whilst not wanting to worry them could have explained the situation a lot better because when they got the news that the baby had died, they were completely shocked.”

4.21 “My milk did not come in for 13 days, so we returned to hospital at day 5 for jaundice because it turned out I hadn’t been giving baby enough food - other than a series of paperwork attached to my notes to go home with about urination and faeces I had no recollection of being told about looking out for these and considering we were only at home for two days before going back in we did not feel like we even had a chance to think about monitoring that without being told how important it was.”

4.22 “I did not know who my named midwife was until I was 38 weeks pregnant”.

4.23 “I requested a debrief but don’t feel that it was really valuable and cannot now recall everything that was said. There was something about high blood loss and some clinical feedback.”

4.24 “ I was told I had to have an induction at 40 weeks but phoned to ask when and was just told how busy the unit was, no one told me about the risks or benefits”.

Theme Two – Trauma and fear

4.25 "At this stage I was really unwell, and things seemed to escalate quickly. There was a sense of urgency in the room, and I was told quickly, around 3.00 – 4.30pm that I had pre-eclampsia. The midwife who was caring for me seemed unsure and inexperienced and was in panic mode, often going to check and ask questions of colleagues."

4.26 "When I was on the ward, I was monitored and every time I felt I was having Braxton Hicks contractions the baby's heart rate dropped. I was relieved I was there, however. I was assured by the midwife looking after me, 'We are on to this, don't worry.'"

4.27 "The birth was a total blur; I was not always aware, and it was difficult to understand how the situation changed so quickly. My labour is described… in the way I do recall. It was an incredibly traumatic birth, including the immediate aftermath."

4.28 "I do not know the name of the midwife in charge, but her and a lovely lady… took great care of me during the scariest most traumatic experience of my life. I was quickly moved to labour ward where I was on one-to-one care until… March. I was fortunate enough to have the majority of my care done by three midwifes… All three are amazing women who are a true asset to the trust. They cared for me, my baby and my husband. They were kind, empathetic and compassionate. They could not do enough. The doctors and consultants were also so kind and caring. They kept me informed multiple times a day. They have such a wonderful team working in Singleton and I am alive today with my family because of everything they did for me. I honestly cannot thank every member of staff that played a part in my care enough. Without them I truly believe I wouldn't be here."

4.29 "Thankfully, the consultant came, and he said it was cruel and inhumane to be kept waiting and not told anything. Eventually two hours later she had an emergency caesarean section."

4.30 "After pushing for 90 minutes a doctor came and examined her. R said that this was very painful, and she was thrashing about in pain and knocked the doctor's hand away. Despite R apologising, R said that the doctor appeared very angry with her, and she heard the doctor say something like 'you are not going anywhere' and suggesting that they try using forceps and if this failed, she would have to have a caesarean section."

4.31 "I thought I was going to die, and my baby was going to die…" (Llais feedback)

4.32 "It was a long time before S could talk again about her experience, which has left her traumatised and caused a period of postpartum depression that she had to receive treatment for. She came out of hospital feeling humiliated and afraid."

4.33 "L was very scared and because of this she asked for early scans, for support for mental health and reassurance. Because her baby…passed away due to placental issues, L wanted to ensure that staff kept an eye on things. She was not allowed scans because her second pregnancy was okay, so she paid for these privately which was very costly. There is a clinic for women who have lost babies or had miscarriages, but L couldn't access this because her second pregnancy resulted in a living child. The bereavement midwife tried to challenge but the consultant would not allow it. The bereavement midwife was very good and supportive."

4.34 "The birth trauma that I have experienced in this country has shocked me beyond words. Thanks to the midwife that risked all that she could to save me when my daughter was having fetal distress! I am telling this story, and my daughter is alive because of her - God bless her forever! While the doctors were telling me that everything was ok with my daughter (she had the same cardiac signs three days before) and he was not concerned at all; when she was born she was not able to breathe by herself, had massive cardiac problems and was rushed to the NICU unit! Singleton Hospital consultants are the worst. I am experiencing post traumatic trauma and it's not easy. [There is] no help for mums at all"

4.35 "It's taken me years to be able to talk about it. I was so poorly after I gave birth, the antibiotics I needed were delayed and if I had these the trauma I experienced could have been avoided. Each year on my child's birthday I feel re-traumatised by what happened".

4.36 "We were told 'if you come in it will stop labour'. We felt that the way we were greeted demonstrated a lack of compassion and that we seemed to be a burden or a problem. We want to emphasise that being listened to is important and the situation that developed into an emergency may not have happened if the messages we gave before coming into hospital and when we arrived, had been heard and acted upon. It seemed to us that the staff had been caught off guard."

Theme Three – Feeling ignored

4.37 "I felt that I couldn't argue when faced with expert opinion, even though I knew it wasn't right. Because of this experience, I have distrust towards health care professionals."

4.38 "One issue was that my complaint couldn't be considered as a whole account of care, and I found that I had to complain separately about hospital and primary care with responses from different people. No one made sense of the whole story. It was also really hard trying to complain when you are on maternity leave. I wrote about my concerns during the night when my baby was asleep."

4.39 "I was not believed during my labour that I was actually in labour. It was a high-risk pregnancy and labour, but nothing was prepared for us. I birthed without a midwife and almost without a birthing partner."

4.40 "I cannot shake off the need for answers about my care. The review and debrief process did not provide the answers I required or assurance that care could be different in future circumstances for women experiencing this situation. How will the Health Board change and improve the feedback process?"

4.41 "I feel that women will continue to be unhappy if they have questions and there is no clear process for a response. I was lost in the system following the debrief and any subsequent review. The process for action on learning does not seem to have been triggered."

4.42 "The day I went into labour I tried calling the midwife numbers I was given. I was unable to get any answers on the office number so spoke to an on-call midwife. I expressed to her I was in severe pain with increased discharge and that something was wrong. I expressed to her I couldn't sit down. This was around 10am in the morning. In that call I told her I was really worried. Her reply to me was rather sharp and she said I was not bleeding so the baby was fine, and it was most probably due to ligament pain with uterus expanding or a urine infection."

4.43 "Unfortunately, towards the end of this pregnancy things started to go the same as her first pregnancy. J spoke with the consultant but felt it wasn't taken seriously. J felt that because she had been so worried about placental issues, she knew more than the consultant. She was fobbed off with 'history won't repeat itself.' Every day she was in hospital she felt on edge."

4.44 "The account from the consultant didn't match what I remembered happening during my time on the ward. I told her that what she was saying wasn't true. I asked why they didn't get him out earlier, but she said there was nothing they could have done. My mum also questioned her and said the consultant's version of events 'wasn't quite what happened, was it.' I knew there was a big issue and that something could have been done differently"

4.45 R said that the doctors were not empathetic and that one said to her, "if you don't go upstairs your baby will die." R felt that using 'scare tactics' like this were not helping her blood pressure. She tried to convince them that she was better off at home but commented that

"they became very defensive and told her that she did not understand what they were saying despite her telling them that she did."

4.46 "You don't want to complain at the time; you just want to get out of there with your baby. I spoke to the midwife after I was home because I wasn't happy with the care on the ward, but nothing happened…they said that they would investigate my care because I bled after giving birth, but I haven't heard anything else about this. That was 18 months ago."

4.47 "During pregnancy, birth and afterwards you feel vulnerable, you are easily brushed off when you ask questions, made to think it's just hormones making you feel like that. I felt guilty and that I didn't speak up for myself."

Theme Four - Compassion and care

4.48 "The bereavement midwife was amazing and …still receive support from her now… The consultant whilst dismissing her concerns recognised that she needed to have a section as soon as possible for her mental health wellbeing."

4.49 "Learning points: good communication by health professionals should be accurate, kind and individualised to understand each woman's clinical outcome. Blame should never be attributed in any way on clinical outcomes."

4.50 "I was told that there was no heartbeat and that my baby was dead on my own. I was then put in a side room with a healthcare assistant who just wanted to keep hugging me. I had to tell her to stop and go away. I needed time to process the news."

4.51 "The family had a letter to say that the Health Board would be doing a review of care. When the letter arrived a year later with the results of this it said that there was nothing the hospital could have done differently to achieve a better outcome."

4.52 "Being told over the phone 'sorry to hear you're having a miscarriage; can I take your email address to send you leaflets on how to cope at home?' was quite possibly the most disgusting thing I've ever heard. There's absolutely no care provided to grieving parents. There wasn't two years ago, and there wasn't with our first miscarriage in 2013 either."

4.53 "Having been at the hospital for a while I cannot fault the staff and how they looked after me and baby."

4.54 "C feels that she was discouraged from using the call button by staff, that she was treated as an inconvenience and ignored…I want to reiterate at this point that this was her first baby and add that she had never been admitted to hospital at this point."

4.55 "The ladies on the Labour Ward will always be my heroes. I wish I could remember their names. The next ward became hell, and although my baby was in hospital I wanted nothing more than to be discharged as I was isolated, lonely and feeling depression coming on."

4.56 "Eventually, after a traumatic birth including an episiotomy, my baby was born but he was blue and not breathing. Her episiotomy wound was stitched without anaesthetic which was painful as the pain relief was wearing off. I am Muslim and my dignity was not maintained, although the male consultant was aware of and respected my cultural needs".

4.57 "I didn't know how to access support to find answers and was told an investigation was underway but the midwife who saw me at a clinic appointment said, "let's talk now about your experience." I felt unprepared, so a 'Teams' meeting was arranged for a later date, but this was cancelled. My experience has left me feeling isolated and depressed and like a "bad mother."

Theme Five - Decision making

4.58 "When I said no to the midwife, she was shocked, but I had done some research and knew that this wouldn't help me."

4.59 "The midwife I met after the birth said, 'I bet you wish you had chosen an elective section now.' My decision was made to avoid major surgery as I had another child, and I thought I could recover better."

4.60 "Five doctors attended to persuade her to stay in the hospital at one appointment. She felt that they all would say the same thing and get aggressive when she was determined to go against their advice. R felt that they were treating her differently due to her heritage and her religion. R accepted what they were telling her but said that, "she knows her own body and wanted to do what felt right." She said that "the doctors would not accept my decision and that they were rude and aggressive." R commented that, "only the Head of Department was empathetic."

4.61 "Having a member of staff on top of me not long after giving birth, trying to latch my baby onto my breast. The information given by every member of staff was different on breastfeeding. With one member of staff, we breastfed, and we were doing well, then a shift change came, and another member of staff thought I couldn't breastfeed so gave me nipple shields to try, with no exit strategy."

4.62 "I was pressurised into staying in hospital when there was no medical reason for this. I would have been more relaxed to breastfeed at home. The antenatal information was different across all communication points/people I met. It's been all out a strain on my experience of becoming a mother, it's left me suicidal at times, I will now be doing therapy to recover and trying to get back the little bit of happiness I have after this treatment."

Theme six - Access to care and services

4.63 "Having a baby puts your body into shock, but then you are told you have to complain within six months."

4.64 "Women and those supporting them at home need to be reassured that they are receiving advice based on consideration of all the relevant factors. If someone has real concerns about their situation, should they automatically be dissuaded from coming into the maternity unit?"

4.65 "Language line is not very helpful. The person on the other end of the phone does not give an explanation of the medical terminology. They don't check that I understood what I was being told. It needs a person on site. They do not use a caring tone it is very bland and matter of fact. Also, they cannot guarantee to get someone who speaks your mother tongue and languages differ slightly so not everything is translated properly. For instance, you may get someone who speaks Cantonese not Mandarin."

4.66 "Postmortems are taking far far too long, although I am not sure this is something you can help with but thought I would highlight it as an ongoing issue; over 12 months in a lot of cases, and this is an issue for those wishing to get pregnant again."

4.67 "The bereavement room!! I feel like a broken record on this one… but honestly this is the most important focus for myself this year. Apparently, the room we had been promised as the perfect solution to all the needs has now been taken away, I am unsure as to why, but this is a massive hit and really frustrating! So many other hospitals have a dedicated maternity bereavement suite, with a double bed the parents can stay in with the little ones, soundproofed and self-contained, yet Swansea still hasn't found a way to provide this service."

4.68 "Why is it such a struggle to get mental health support. When I asked for it I was told that because I wasn't suicidal, I could not have it. Even the bereavement midwife asked for it and

was told no. I get flashbacks of the first pregnancy. I do not want to be treated by the midwife that was in the assessment unit as I am sure this will give me further flashbacks, and I could not stand it."

4.69 "I was anxious about having a second child as my first son was born during the Covid-19 pandemic. I describe my first birth as "just happening to me" and my second birth as being "given choice, being listened to and having a positive birth experience. I didn't know what was normal and I asked the midwives to, 'treat me like a first-time mum.' The midwife was brilliant and read me like a book. I chose to give birth in the midwifery-led unit at Singleton and was encouraged by my midwife to visit the unit and she completely understood my choices".

Theme seven – Birth partner and separation

4.70 "I was not able to stay longer than two hours after my partner's birth as she delivered our son at … hours and I had to drive home after being awake myself for over three days and she was left with our son, and she needed to rest. I should have been able to stay."

4.71 "Due to Covid restrictions, I was barred from entering the building, meaning that my wife had to enter and take the lift to the building's 3rd floor, where the maternity unit is located, alone. No staff offered to help her in or out of the building."

4.72 "Other mums on the postnatal ward had their babies with them and mine was all alone on SCBU [Special Care Baby Unit]. I felt so alone as my husband couldn't be there because of some regulations. I am still very upset. The hospital needs a separate room for mums who have babies on SCBU. This is very important; seeing other mothers enjoying their babies whilst mine was in SCBU is like a second impact."

4.73 "I loved the fact they put my name as a dad on the door as well as mums name, it made me feel more involved and welcomed which I've never had before which is really nice especially from a dads point of view all the staff are friendly and helpful and answered all my questions."

4.74 "Baby…was born by emergency section, and she was stabilised before admission to NICU. My partner waited for nearly six hours with no information, and this was the hardest time."

4.75 "They want you to hold the baby, but you don't know what is going to happen. She was going to be moved to the NICU. Not all of the placenta had been delivered so was rushed off to theatre. Fibroids were also discovered during the surgery. D was left in the delivery suite all on his own and didn't know what to do."

4.76 "I understood that the baby was still stressed and just felt that everything was in a freeze frame. I felt that my baby was lost. My mum arrived as it had taken her a while to travel in. It was a sad situation as she arrived when the situation was deteriorating, and she was out of the loop. She started to ask why nothing was being done."

4.77 "There was no support. The medical staff checked on me, but I was totally alone. I could not move, other than to go to the toilet. I was not supported mentally either for me or my babies. There was no mental health support at all. The staff were just there to perform their duties. I was all by myself and felt so lonely. My husband couldn't be with me, and we have had no support from our family…alone."

4.78 "I went down to NICU to collect my baby to bring her back to the ward and she wasn't there, nobody had told me she had already been taken to the ward, so my little baby was sat in the crib in the middle of reception until I got back! She suffered loads of bruising and cuts to her body during birth which wasn't documented in the notes in the red book, for me then to be accused and questioned of hurting my baby by the aftercare midwife after we returned home!"

4.79 “My son’s dad missed the birth of his child because he wasn't allowed in until I was 4cm which meant if someone would have checked me like I told them to do many times, he would have been there because according to their chart I went from 1cm to giving birth, without anyone checking for progress in between. I will literally never forgive anyone who was working that night and that one night has played a huge part in why I will never have another child.”

4.80 “My birthing partner was unable to be with me as this was outside of visiting hours, therefore due to the incompetence of your staff I experienced my labour on my own without any support or reassurance.”

4.81 “I was referred to the PRAMS service (Parental Resilience and Mutual Support) and received extremely valuable trauma support and counselling. There has also been an impact on my husband, and it would have been helpful for him to access support.”

4.82 “I had four babies in Singleton Hospital, “two births were fairly good, the other two, not so much. The staff refused to let me go up to the labour ward. My husband advised the staff to follow health and safety procedures. He was asked to leave because it was past visiting hours. I was in the final stages of labour, but the staff did not believe that I was and left me unattended.” The husband did however stay with her, and he had to deliver the baby himself as there were no staff present. She told us that, “he caught the baby with one hand and pressed the emergency button with the other.”

4.83 “Having a baby in NICU is triggering. We needed psychological support, and the Bereavement Midwife is lovely, works so many hours and supports people but she is so stretched that not everyone can be seen. My husband managed to get support from his own Occupational Health Department in the end.”

4.84 “A client of mine had a traumatic first birth in Singleton and wasn’t believed she was in labour so her husband wasn’t allowed in (she’d been in for an induction, but it was delayed, and it was outside visiting hours). She did lots of the birth alone not being believed and told it was another kind of pain. She had to beg to move to the birth centre but due to her being post-dates there was conflicting information. Her husband was only allowed in at the last minute. She was traumatised so used…services again for her second birth and hired a doula to be another advocate. She again wasn’t believed about her being in labour and the doula was denied entry and missed the birth. My client is again traumatised about what happened to her this time. Not being believed. The midwife tried to get her to lie on her back which wasn’t what she wanted.”

4.85 “For the sake of my own wellbeing, I needed to feel that my wife was being treated with kindness and dignity, and so I was dismayed by the messages that I received from her while she stayed in hospital.”

Incorporating other sources of feedback

4.86 A range of established feedback mechanisms are already underway to understand the views of women and families using maternity and neonatal services at SBUHB:

Maternity Voices Partnership

4.87 The Swansea Bay Maternity Voices Partnership (MVP) is an independent multidisciplinary advisory and action team, working together to review and contribute to the development and continuous improvement of local maternity care. It is led by an independent lay Chair and Vice Chair who ensure service users are represented.

4.88 The MVP uses an online survey which is available to people (including birth partners) who have used maternity services within the last five years. The survey asks questions such as: What went well? What could have been done differently to improve your experience? What

matters most to you within maternity services? The survey also includes a comments section for any other feedback respondents to the survey wish to provide.

4.89 We were provided with the survey data and comments provided to MVP between 2019 and February 2025. This data was not broken down by year and therefore we have been unable to analyse the data to show any changing trends over this period.

4.90 MVP capacity is significantly challenged; the underdeveloped analysis of survey data reflects this. There have also been a number of personnel changes, as well as periods of vacancy and interim solutions. We heard frequently of the ambition to elevate the work of the MVP, including expanding its remit to cover neonatal services. Key to realising this ambition will be ensuring that the service is resourced accordingly.

4.91 Illustrative comments from MVP data include:

"Please reinstate antenatal education classes. Inform women about all their birth choices, especially in Labour Ward where some people don't know they can have water birth or even use the pool."

"Inform women about conditions to leave Postnatal Ward after birth when they are admitted at the Postnatal Ward, such as baby needs to poo and wee at least once."

"There was no cot for my daughter when she was born, myself and my partner took it in turns passing her and napping. I understand skin to skin is important but the option to put her in a cot was not there, just nothing available. Also refused paracetamol until I ate some Weetabix, I had eaten toast after giving birth only a couple of hours before and some paracetamol would have just about touched the sides but would have been something. When I had eaten, I was forgotten about, my partner had to keep chasing up pain relief. The unit just seemed short staffed"

"I didn't receive any information about postpartum depression, only from my own research but nothing from the hospital or midwives or any advice to possibly help baby blues."

Friends and Family Test

4.92 The Friends and Family Test (FFT) is an established questionnaire in use across England and Wales. For the months between April 2024 – March 2025 there were 1,562 FFT survey returns. We have extracted the data relating specifically to maternity services.

4.93 For the months between April 2024 – March 2025, there were 1,562 FFT survey returns received by the Health Board. Of the FFT feedback results over the year, 91% provided a positive reflection of services. The survey went on to ask respondents about the overall experience of the service they were utilising. There were two key areas for improvement: the Antenatal Assessment Unit and clinic at Singleton. The report also highlights that, of those respondents reporting negative feedback, it is the behaviours and support given to women which requires improvement.

4.94 Feedback given to the Health Board directly via survey routes is overwhelmingly more positive than the experience of women that we have heard from. There are known limitations with the use of FFT data[44] including, difficulties with the meaningful analysis of free text data and the capacity and resource to analyse the data properly, to extract themes and trends and to take meaningful action.

4.95 The use of FFT data alone, could promote a confidence or confirmation bias in a service's understanding of the care it delivers. The gaps between FFT data, complaints and other sources of feedback should be much more comprehensively understood in maternity services, to avoid the emergence of confusing or even conflicting messages about care.

4.96 The key strands of feedback from FFT highlight that the main areas for improvement for the service would be:

Pathway stage	Comments
Antenatal	• Women not being listened to. • The attitudes and behaviours of midwives. • Access to services including the lack of a home birthing option and the midwifery-led unit at Neath Port Talbot hospital (both these services were stopped during Covid-19 and were only restarted during 2024).
Intrapartum	• Induction of labour – the 'start-stopping' of this. • Positive experience of midwives when in actual labour.
Postnatal	• Whilst there were some positive experiences of staff attitudes and behaviours, in the main this was not felt to be positive. • Women would have appreciated more support and advice post delivery than they received. • Access to mental health services after traumatic experiences.

4.97 Women from seldom-heard groups were generally more positive in their feedback than their counterparts who spoke English or were of Welsh heritage. Women were generally pleased to be able to access "free health care", to have access to advice and information, and for partners to be involved in care. However, their comments on areas for improvement included postpartum care being more compassionate and access to pain relief. They also highlighted the need for a better translation service, for doctors to match women's ethnic origin, and access to a variety of food.

Llais report of May 2025

4.98 Llais is the independent body in Wales whose role is to understand the views and experiences of people and communities who use health and social care services to make sure that their feedback is used by decision makers to shape services.

4.99 Llais (Neath Port Talbot and Swansea) became concerned about maternity and neonatal care following the Healthcare Inspectorate Wales (HIW) reports in 2023 and 2024, concerns expressed though Llais' complaints advocacy service and through their engagement activities.

4.100 Llais conducted research in October 2024 using a survey, in-person and online focus groups and interviews to hear a wide range of experiences from 515 people. In May 2025, Llais published their report to share the feedback received, 'Having a baby in Neath Port Talbot and Swansea, Experiences of maternity and neonatal services in Swansea Bay University Health Board.'

4.101 Some women and families shared good feedback but also talked about significant challenges in their care, and mixed experiences of what went well, what helped and what didn't go so well, often within the same response.

4.102 A number of key themes and issues that were important in care emerged from the report's analysis of feedback:

- Quality of care – consistency, continuity and compassion throughout care.
- Information and communication – clear understandable information and conversations.

- Being involved in decision making – choice and clear information to be part of decisions.
- Respect and compassion – pain and concerns being taken seriously and not dismissed.
- Being heard – the value of being listened to, having time to talk about care and concerns.
- Being cared for after giving birth – having the right support and care to be well and look after their baby, feeling safe, postnatal community and mental health support.
- Barriers to care for people from ethnic minority backgrounds – understanding cultural needs, appropriate support to manage pain, access to information in the right format and language.
- Unsafe care – importance of well monitored safe care, listening to and acting on concerns when they thought something did not feel right.
- Understaffing and work culture – culture, staff levels, care, compassion and staff availability as important as clinical processes.
- Raising concerns – clarity about who to contact, how to raise concerns, and the quality of the response.

4.103 The report stresses the importance of families being able to influence future Health Board decisions, strengthening existing changes, ensuring poor experiences are not repeated, supporting staff providing care and making sure that people's voices are heard and lead to better services.

4.104 We have ensured that the suggestions for further action made by Llais within their work have been included within the main recommendations of this review.

Part 2 – Analysis of experience feedback

Understanding feedback on experience

4.105 The experience of pregnancy and giving birth is one of the most defining and important moments in a woman's life and in the life of a family. A positive and safe birth experience is a woman's right. Every parent should, equally, have the right to an expectation of the quality of their child's life. And, whilst the focus of care being upon the woman as birth-giver has some inevitability, birth partners are also owed a duty of care, understanding and recognition.

4.106 The way a woman expects her birth to be and how she then experiences birth is unique to each individual and is dependent on many other variable factors in her life. Those variable factors (frames of reference) include age, ethnicity, religion, class, education, history, wealth, social status, physical health, mental health, relationship status and family status, amongst many other things. Each woman and indeed each birth partner, when asked about birth will provide an account of that experience which prioritises some aspects of that experience over others with a greater value placed upon what mattered most to them and their family.

4.107 Other factors which impact experience might include aspects such as first or subsequent pregnancy (from research, expectation tends to be rebased on subsequent births), past trauma, levels of support that the woman has at home and also the way the woman emotionally processes her experience (this can be significantly impacted by, for example, a history of childhood or sexual abuse).

4.108 Hypervigilant emotion processing as the result of hormonal changes in the brain can influence women to better detect fear, threat and to recognise the emotional signals of others. Hypervigilant processing during pregnancy and birth and as the result of trauma processing, is part of the reason why women remember their birth experiences in (often) minute by minute detail; and this can often extend for life. Hypervigilant processing may well

be under-recognised in maternity and neonatal services, particularly in how services respond to trauma in a psychologically safe way.

4.109 Childbirth involves 'special vulnerability[45].' Many women will describe at least some aspects of their pregnancy and birth as in some way traumatic. For some women it is their first experience of a major procedure or of being meaningfully treated in the hospital setting. Pregnancy and birth is a special time, but it can also be fearful, uncertain, almost certainly invasive in several respects, and ultimately, not without inherent risk. It can be an experience which is both joyous and scary in equal measure and is frequently unpredictable; the lack of predictability can be, in itself, a cause of stress.

4.110 Good antenatal care is an essential foundation for a positive experience of birth and early motherhood. Not only is this to identify risks and physical health issues at an early stage, but also to build confidence between the mother and her care team particularly in the ways that she feels cared for and listened to. The antenatal period is a profound part of the pregnancy journey where expectations can be identified and managed, particularly via the establishment of contingency care plans if a woman's first expectation is not met, to better align the actual experience of birth and the mother's association with what a 'successful' birth looks like.

4.111 Experiences of 'success or failure' in childbirth set a tone for motherhood that may have long-lasting effects on the mental wellbeing of the mother. A positive childbirth experience can empower the mother and has the potential to strengthen her self-esteem and self-confidence into the long-term[46]. Whereas a negative experience (particularly in a first pregnancy) can affect the mother and her new family for a substantial period creating a fear of childbirth – which, in itself, is a psychological burden. This can lead to requests for a caesarean section in future pregnancies, or avoidance (or delay) of subsequent pregnancies. There are large differences in reported expectation and experience between first and subsequent pregnancies.

4.112 Fear is known to play a central role within the experience of childbirth and the care team is essential for supporting a woman to process her fear by 'normalising' it. Additionally, recovery from a negative childbirth experience could be vastly helped by midwives not trying to correct the perception of the experience, but at the same time not refraining from 'filling in the gaps' by providing supplementary Information only when needed[47].

4.113 Many people we spoke to were keen to stress their compassion for staff at the Health Board and recognised that staff were often trying to deliver care in difficult, complex, and rapidly changing circumstances. Indeed, in a large proportion of the feedback, many women reported at least one aspect of care which was positive or a good experience although we heard less experiences which could be described as 'universally positive.'

4.114 It is also important to remember that many women do have a positive experience of pregnancy and birth although exactly what percentage is difficult to determine for some of the reasons outlines in this section. In the 2024 Care Quality Commission (CQC) Maternity Experiences Survey, of 18,951 who responded, the CQC state that a 'significant' proportion of those women had a positive experience.

4.115 There are issues with the ability of services to gain full insight into experiences, particularly using surveys. Often, women will describe both positive and negative experiences and often they will refer to multiple care interactions along their pregnancy, birth and neonatal journey. Therefore, there is a strong argument for maternity feedback to be analysed using much stronger qualitative analytic techniques, particularly through the analysis of specific comments rather than trying to make a single judgement across a whole care episode.

Research on common themes

4.116 Research shows[48] that there are some shared features which tend to underpin negative experiences of pregnancy and birth, including:

- **Mis-assessment** – the perception of actions or decisions taken by doctors or midwives as being inaccurate.
- **Care providers' disagreement** – midwives and doctors having different opinions of actions needed, particularly during the second stage of labour (actual disagreements and perceived unspoken tensions) between the team.
- **Betrayal and disrespect** – feeling pressure from the care providers to make certain choices about birth plans and pain relief; then having birth plans that no one respected, a lack of informed consent and loss of autonomy.
- **Neglect** – not being involved in decisions made during pregnancy and labour with a focus on the technology in the birthing room instead of the woman.
- **Refused care** – experiences of being denied care at the birth unit (via triage) in early labour, either in a telephone call or at a visit to the hospital.
- **Lack of communication** – not having received enough information during pregnancy, labour and birth, nor explanations of actions taken. Lack of awareness by staff of health history or birth plans despite these being documented.
- **Crowded and stressful environment** – feeling there were consequences for giving birth on a day perceived as busy. Delays in care or treatment (pain relief, induction) and midwives being overstretched on shift.
- **Separation** – women were transferred to recovery without their infant or partner and felt isolated and alone.

4.117 Certainly, for SBUHB there are themes which are directly correlated with the above research, particularly issues around betrayal and disrespect, neglect, refused care, communications and separation. As we will see from the analysis below, we saw less feedback on the environment, mis-assessment and disagreement between care providers.

Detailed analysis under key themes

4.118 The positive impact that continuous care in the community can have on women's experience was evident throughout our conversations with women and families. The Health Board being able to provide midwifery continuity of carer is a central ambition in the Welsh Government's recently published Quality Statement, in recognition of the importance continuity plays in providing safe and effective care.

4.119 Through many of the experiences shared with us, it was striking how **one interaction** between a practitioner and a women and/or family could have a lasting and profound impact. We heard about women feeling seen and empowered seemingly through one conversation with a midwife, and sadly, the lasting emotional damage that could be caused by not feeling listened to at key moments in their care.

4.120 In several accounts, women also gave examples of where the care was good, usually recognising an individual member of staff that had made a difference to them.

4.121 The following diagram shows the frequency of themes which related to care (larger words are more prevalent themes):

4.122 **Theme One analysis – Communication and advice**

We were told that when this is good it looks like:

- Staff do not make assumptions about a woman's need for information, they ask, they enquire, and they go at the speed of the woman.
- People do not have to repeatedly explain their history, including past trauma. They feel 'known' to staff.
- Women are well informed about what to expect and when, for example, the process and time it may take to prescribe medications prior to discharge is explained.
- People felt fully informed about the reasons for an induction being offered, what having an induction would involve, alternative options and risks and benefits (in line with NICE guideline NG207).
- Where there are delays to a planned induction, this is clearly communicated to women and options discussed.
- First-time mothers are acknowledged by the service as potentially needing additional education, guidance and support to feel empowered as equal partners in their care.
- People know the options available to them if they have a concern. Information is provided on how to raise a formal complaint.

4.123 We heard about:

- An appetite for more information on care options in the antenatal period, including benefits, risks and how risks would be managed. This was particularly the case for first-time mothers.
- An appetite for more information on care options in the intrapartum period, including benefits, risks and how risks would be managed.
- Women not knowing who their named midwife was or how to contact them, or who to raise any concerns with.

- A lack of confidence that medical histories and past experiences had been taken into consideration by staff. In some cases, we heard about women being reassured not to worry, such as in the instance of pre-eclampsia in a previous pregnancy, but with limited information being provided about why women should not worry and how the risk of reoccurrence would be managed. Many women felt like their concerns were not listened to by clinicians.
- A need for more information to be provided about when to come into hospital and signs that labour is progressing, such as contractions become closer together.
- Plans changing without women and families being informed and understanding the clinical rationale for change.
- Accessing someone who could provide useful information, particularly to women in suspected early labour, was described as "difficult" and "inconsistent." We were told that finding someone to speak to who could provide reassuring, clinically informed advice could be a challenge.
- Debriefs not being comprehensive, tending towards a chronology of events rather than a clinical explanation of what happened and why, and areas for potential service improvement not being acknowledged.
- A lack of signposting to services such as the Patient Advice and Liaison Service and the Health Board's complaints process.
- Communication between the Health Board and other organisations being ineffective, resulting in disjointed care for women.
- A need to strengthen insight into the needs of women and families from seldom-heard groups.
- Multiple accounts of women not being informed that an induction of labour may be paused and restarted again.

Cross-referencing this theme:

Summary	• What is clear from the analysis is that women would like someone to talk to, to either provide reassurance, advice or to support them in decision making. Leaflets and advice sheets cannot substitute for a vital conversation at the times when this is needed the most. This is not only a capacity issue it also relates to staff being 'emotionally present' during consultations and providing truly individualised care.
The primary linked themes	• A lack of staffing or staffing issues is the largest theme which links to a lack of information or communication. • A lack of communication is frequently linked to women feeling ignored and not listened to. • This is closely followed by women feeling that a lack of information is closely linked to a lack of compassion. • See also 'fear' below.
Secondary linked themes	• A lack of pain relief or access to pain relief was an identified theme in communication. • Trust was also linked to communication; sharing more information, particularly in the form of discussion, would positively influence trust between women and services.

	• Survey data tends to provide a more positive account of the quality of information available, but this often refers to leaflets.
The part of the pathway where this theme is most prevalent	• Most women who reported a lack of communication felt that this occurred in the postnatal period of their care journey. • The second most prevalent part of the pathway where communications was poor, was during an induction of labour.
Variances in year or date ranges	• In most cases either the date was not recorded or there were no significant features across date ranges.

4.124 Theme Two analysis – Trauma and fear

We were told that when this is good it looks like:

- Anxiety is reduced after speaking with staff.
- Notes and care records are updated to reflect women's views on their birth experience and this information is read by clinicians in future episodes of care.
- Women can access pain relief when they need it so that they do not have to live in fear of, or experience, overwhelming pain.
- Bad news is delivered in an appropriate way.
- Women are taken seriously when expressing fear.

4.125 We heard about:

- Access to pain relief being delayed or not available in early and active labour.
- Women feeling worried and anxious about access to services.
- Birth partners feeling totally helpless, and as a consequence suffering their own extreme trauma or PTSD.
- How a single glib or unkind comment can completely undermine how a women experiences pregnancy and childbirth.
- How trauma and fear can be enduring, can change everything, and can change 'you' as a person.
- How trauma and fear influences whether you have more children.
- How a traumatic first birth does not always lead to more compassion in your second birth, particularly when women have to repeat the experience because, for example "a midwife is too busy to remember what was said five minutes ago."
- Conversations, particularly those in which traumatic or catastrophic news is delivered, are not always taking place in appropriate settings which further compounds trauma and leaves people feeling a lack of care and thoughtfulness.
- Women feeling that their concerns, particularly in early labour, were not listened to, amounting to missed opportunities to intervene. We heard accounts of women who experienced this going on to have poor clinical outcomes for themselves and/or their baby.
- Concerns and potential associated risks of not being listened to by triage staff. We were told that this could result in women staying at home in a state of heightened anxiety with potential risks not having been fully considered.

Cross-referencing this theme:

Summary:	• Women become fearful when they have a lack of information, and they feel they are not being heard. The unpredictability of birth and doubts over pain and access to pain relief also creates fear. Trauma results from a direct experience, usually where a woman describes harm. Trauma can also be experienced by a birth partner. Trauma and fear can be reduced by direct interventional emotional support and understanding, which can reduce the (sometimes) life-long impacts.
The primary linked themes	• Fear is frequently linked to a lack of information, advice or communication; this was the most prevalent link. • Women feel that a lack of compassion from staff in the delivery of care directly adds to their trauma. Staff were frequently named when a traumatic experience was reported. • Women report that feeling ignored is a particular feature of trauma and that they did not have agency in their decision making. • A lack of pain relief is directly linked to trauma. • Bereavement and trauma are inextricably linked.
Secondary linked themes	• A lack of access to services can create trauma and fear. • A lack of involvement in decision making was also linked to trauma and fear. • Trauma was not reported more in a woman's first or second pregnancy, there was an even distribution of comments. • An improvement in the process of, and access to, more spontaneous debrief would likely improve trauma responses. • There are four accounts which would qualify as 'obstetric violence' within the feedback. This is where a woman feels that her experience was so traumatic that it was akin to an 'assault' either on a physical or emotional basis.
The part of the pathway where this theme is most prevalent	• The postnatal period was most frequently associated with trauma. • Antenatal care and neonatal care emerged as closely linked to this theme. • Induction of labour was closely linked to trauma.
Variances in year or date ranges:	• In most cases either the date was not recorded or there were no significant features across date ranges.

Theme Three analysis – Feeling ignored

We were told that when this is good it looks like:

- People feeling that their opinion, concerns and 'gut feeling' matters, are heard by staff and are acted upon. Women and families feel believed.
- Women feel that they matter as an individual and they are not 'just another woman.'
- When concerns are raised, women and families feel that these are meaningfully acknowledged.

- Women feel confident about how care plans are reviewed and changed in the light of concerns and risks.
- Women are offered the opportunity to reflect on their birth experience at a time that best suits them. This is done regardless of whether birth 'went to plan' and regardless of clinical outcome for women and babies.
- Feedback to women is compassionate, tailored to the original concern, not defensive and is timely.

4.126 We heard about:

- A perceived disinterest from staff, leaving women feeling dismissed and unsupported. One woman, whose experience was similar to that of several others, told us that, "as soon as they heard a heartbeat, I was sent home with no advice as to what to do or what to watch out for. I felt like I couldn't contact them again as I had been dismissed."
- Feeling you are 'just a number,' or 'just another birthing woman.' There is not enough consideration of past trauma, past experiences (for example sexual abuse) which might totally derail an otherwise positive birth experience.
- Women perceiving an indifference to pain from some staff.
- Women and families who do not speak English as their preferred language reported barriers to accessing services because staff were unable to hear and understand their concerns.
- People being compelled to retell their experience repeatedly to feel understood, rather than notes being read in advance. To some people we spoke to, this process further compounded their trauma. We also heard that notes did not always reflect an accurate picture of care.
- People feeling dismissed and, at times, belittled in their interactions with triage staff.
- When babies are taken to neonatal unit, the woman is "hung in suspension" between her own needs and those of her baby; this is a time she needs her birth partner the most.
- People not having the opportunity to reflect on care with a midwife or obstetrician, either before discharge or soon after in the community. We heard accounts of the failure to do this resulting in people feeling upset, confused and sometimes feeling compelled to access mental health support.
- Women raising concerns about their care at the time the care was provided but not being acknowledged.
- Debriefs being needed but not being available.
- Sometimes what was a concern was treated as a debrief, sometimes what was a complaint was treated as an informal feedback comment. Women and families are left feeling unheard.
- A lack of information, follow-up and feedback following an adverse event. This left some families unsure of whether an investigation was going to happen, what any investigation found and whether an investigation has resulted in any change to practice.
- As soon as the baby was born the focus shifts and you are "meant to get over the experience you have just been through" when you feel you have just been "hit by a truck."
- Postnatally, there were significant issues raised with the quality of care and compassion, a feature which is significant in most large maternity reviews.

Cross-referencing this theme:

Summary:	• The concept of women feeling ignored is pervasive in almost all areas of care and it underpins many other themes. Feeling ignored tends to lead to fear and trauma. It also can leave an enduring legacy of mistrust in services. When women are, for example, using triage they expect to be believed in terms of how they feel. When women are being induced, they expect that their views are considered and not overridden.
The primary linked themes	• Communication (and lack thereof) is directly linked to women not feeling listened to and to limited access to direct advice and information. • Feeling ignored is directly linked to responses about trauma and fear. • Decision making directly correlates with women feeling unheard and not listened to and, (given the overwhelmingly negative responses), women do not feel they are involved in decisions about their care. Women feel unheard at times when they are trying to access services.
Secondary linked themes	• The process of debrief was also significantly linked which, from the feedback indicates that women who would like access to debrief are not always able to get this or it is delayed, leaving them feeling ignored. • Language barriers were also a significant linked theme here and are seen as a direct block to how women feel they are received and understood.
The part of the pathway where this theme is most prevalent	• The part of the pathway where women feel the most ignored is in the postnatal period. • At triage there are several themes around women not being believed or that they feel discounted in their own opinion about their own bodies. • This is closely followed by women feeling ignored and unheard during induction of labour.
Variances in year or date ranges	• Comments and themes were distributed evenly in 2021,2022 and 2023.

4.127 Theme four analysis: Compassion and care

We were told that when this is good it looks like:

- Women feel that they are cared for, and their needs are responded to.
- They are treated with kindness, dignity and respect.
- They are treated as an individual, as a human and as a new mother.
- Women are not seen “as a pain” for needing reassurance.
- They are treated by staff who have energy, time and a positive regard for their welfare.

4.128 We heard about:

- Kindness and compassion, even when things have gone wrong, is without limitation the most important thing to help a women get through her experience.

- Women who felt their care team were putting them first and advocating for them and that they mattered.
- Women feeling, that on occasions, care was almost “cruel”, with perhaps staff passing on their frustrations directly.
- The frustration of clinicians being apparent.
- Women feeling judged and blamed when discussing their clinical presentation and the journey of care with clinicians.
- The concern of clinicians and lack of confidence of clinicians in what is happening being very evident. Equally, the overconfidence of clinicians was not always helpful as it eclipsed the woman and birth partner in their experience.
- Women’s dignity being compromised by poor cleanliness and a lack of support to use the bathroom.
- Women feeling ignored, uncared for and unsupported; although several referenced how busy the postnatal ward was.
- A lack of reassurance, transfer of knowledge and understanding from staff.
- If a baby has died, the mother must still be treated as a new mother.

Cross-referencing this theme:

Summary	• Compassion is an essential ingredient in any birth experience whether it is deemed ‘positive’ or ‘negative.’ Seeing the woman (in her family context) as an individual, with unique fears and expectations is important and can underpin memories of pregnancy and birth which last a lifetime. On a busy ward or clinic, it is easy to not see the individual. It is also to see the impact of compassion fatigue on the energy and focus which is given at each care intervention. Every single contact should be made to count at every stage of the pathway.
The primary linked themes	• Access to pain relief and medication are emerging linked themes when women talk about compassion and care. • Feeling ignored and being involved in decision making were also significantly linked. • The birth partner emerges as a significant feature within this category, and they are seen as a vital ingredient in women feeling they are being treated with compassion by others. However, a lack of compassion shown by staff is pronounced in this theme. • More compassionate approaches are reported with community midwifery teams.
Secondary linked themes	• Support with breastfeeding is a pronounced linked theme in how women describe compassion. Women may be trying to breastfeed for the first time, and they feel that advice and patience are frequently lacking. • Being helped with cleanliness, pain relief and being provided food and general help with mobilising in the postnatal period was also a correlating theme when women discussed compassion.

The part of the pathway where this theme is most prevalent	• The postnatal period (starting from immediately after birth) is where issues with compassion appear most prevalent. • The antenatal period is linked to several concerns about compassion, particularly, this is linked to women having to repeat their histories, have their concerns answered or when trying to access triage.
Variances in year or date ranges	• There are no significant variances in date ranges shown.

4.129 Theme five analysis: Informed decision making

We were told that when this is good it looks like:

- Decisions are made with women, rather than about women.
- Women feel confident that if they don't have their planned birth, they are fully aware of contingency plans and other options.
- Women do not feel forced into induction of labour (IOL) to meet the needs of the service.
- Women feel they have a choice about induction based upon the best advice.
- The whole team is on board with the decision and not expressing different preferences.

4.130 We heard about:

- There is an assumption that women have sufficient information to make an informed and fully rounded choice.
- Risks are not fully explained. In the "chaos" of a delivery suite or theatre, people stop talking. When the worst happens women and families still want to know what can happen, the risks, and anything they can do to change the outcome.
- A leaflet does not replace a conversation which is centred around the person and their unique needs.
- There is insufficient 'checking in' on what a woman knows, feels and perceives, and what a woman needs in terms of information. There is an assumption made – which is paternalistic – that knowing the risks in all cases will just 'scare' the women. There are many different ways of providing information.
- Women feeling like IOL is a way of managing patient flow, not prioritising clinical need.
- Women not feeling sufficiently involved in the decision to have an IOL.
- We heard a number of accounts of women feeling that they were pressured into an IOL without being supported to understand the rationale for this being the best possible clinical intervention.
- A lack of briefing being provided on the risks and benefits of an IOL and any other alternative options.
- Women not being given the opportunity to decline, delay or stop an IOL when there were no beds available on delivery suite.
- Responses to concerns seeming defensive, lacking empathy, not addressing the original concern, and in some cases inaccurate accounts being included in responses, which causes further anxiety and trauma.

Cross-referencing this theme:

Summary	• Sometimes it appears that staff feel that they know what is best for the woman and that their interventions can easily overshadow a woman's need for agency in what is happening to her own body. Women sometimes feel that they are making decisions within a void of insufficient advice and information. In some instances, this extends into them feeling that there has been a complete lack of consent. Better planning at the antenatal stage is required so that there can be an alignment of expectation, knowledge and action.
The primary linked themes	• By far the clearest linked theme here is in relation to information and advice. • The second most distinct linked theme relates to staff, access to staff and the conduct of staff. • The third most pronounced theme is feeling ignored and discounted; women who feel their decisions are overridden or dismissed. Additionally, women who are not able to access the decision-making process because of language or communication barriers.
Secondary linked themes	• There are linked themes around pain relief and medication; it is likely that this is particularly if there was an expectation of pain relief in the birth plan. • Whilst consent did not emerge as a large theme within all of the feedback analysed, it did emerge as an area linked to decision making. There is a particular issue of the bodily autonomy of women when they feel they are excluded from decisions and information.
The part of the pathway where this theme is most prevalent	• There is more commentary linked to the antenatal period with the addition of care in community settings. • There are particular links to access to services via triage and also induction of labour.
Variances in year or date ranges	• There are no particular variances in date ranges over years.

4.131 Theme six analysis: Access to care

We were told that when this is good it looks like:

- Access to support from triage is the same for those who need translation or interpreting services, as for those who do not.
- People have clear information on how and when to contact the triage service.
- People could easily access support from staff in triage, either via phone or face-to-face.
- People feel that they are responded to based upon clinical need, rather than the order in which they 'sit' in a queue.
- The possibility is offered of going home in the early stages of an induction of labour.
- Informed birth choice being available along with the risks and potential outcomes being fully explained.

- Women are supported to breastfeed if they wish to. Feeding choice is not influenced by how busy units are.
- Specific support is provided to women who have babies in NICU to minimise anxiety and stress.

4.132 We heard about:

- Differences in experience at all parts of the pathway with the poorest experiences consistently being in postnatal care.
- Differences in care delivered at the weekend.
- Not always having access to pain relief when needed.
- Some women and families feeling unwelcome when arriving at the unit and a burden to staff.
- Women waiting for significantly extended periods of time for treatment, sometimes with a lack of understanding of why or what to expect next.
- A lack of information regarding self-management, such as how to spot signs of infection and what to do if this occurs.
- Delayed discharge due to the need to complete paperwork or prescribe medication.
- Some women not being aware that they can access support from their community midwife for up to 28 days postnatally.
- A lack of physical support to women who have babies being cared for in NICU, such as access to postnatal checks on site at Singleton Hospital for women with babies in NICU, as well as supporting women on the postnatal ward to visit their baby.
- Inadequate or unavailable breastfeeding support, including for women who have had a caesarean section. Several women highlighted they were promised support, but it did not materialise due to staff being too busy.
- Limited capacity from bereavement specialists, although those who received bereavement support praised it.
- Lack of access to postmortem results for an extended period of time, leaving women and families in suspension and unable to move forward in their grief.

Cross-referencing this theme:

Summary	• With more available information women could better help themselves to access their own solutions and care. Women also want to know that they are heard and believed when they feel it is the right time for them to access the care they need. Access to some vital care, such as psychological or bereavement support is limited, and this can directly impact upon the new family and the early stages of bonding.
The primary linked themes	• Access to care cuts across other themes and encompasses pain relief, feeling ignored, trauma and communication. • Information is a particular feature where women feel they could moderate how and when they access care with the availability of more information so that they can make a judgement. • NICU emerges as a distinct theme here, in the way that women are immediately confronted with the boundary between their

	own care needs and that of their baby. This is a cause of particular distress because of the circumstances of families often being separated.
Secondary linked themes	• Language barriers are highly relevant here. • There is also an emerging theme about team working; women feel they are being told different things by different people. • The business of the department and how 'stretched' staff appear to be is also linked to this theme.
The part of the pathway where this theme is most prevalent	• The postnatal period (starting immediately after birth) particularly where this is linked to neonatal care. It is clear that some women can feel abandoned and unaware of how they can access help and support. • Access to triage (we recognise women do not always refer to this as triage) where women are in early labour, wanting to come in, and are either dissuaded or are not believed.
Variances in year or date ranges	• There are no notable variances in date ranges across particular years.

4.133 Theme seven analysis: Birth partner and separation

We were told that when this is good it looks like:

- The birth partner is included and welcomed as an equal.
- Birth partners not asked to leave in the postnatal period.
- Partners are involved in the postnatal period.
- There is an awareness that birth partners can suffer trauma too.
- If women are separated from their babies that this can be highly traumatic and extra care and support should be given.
- Staff keep women and birth partners informed during labour about what could happen next.

4.134 We heard about:

- Partners/family members feeling unwelcome and their concerns not being listened to.
- Partners being perceived as there only in a support role rather than as instrumental to the whole process and experience of pregnancy and birth.
- On occasion, partners being dealt with on quite a dismissive, hurtful basis.
- Birth partners not feeling included and attempts to advocate for their partner being unwelcomed.
- Birth partners being excluded because of "the rules" (and also those rules being inconsistently applied).
- Birth partners not being able to fully participate in key moments because of overly restrictive and (seen to be) fairly out-of-date practices around visits.
- We also heard of a lack of consistency in the protocol and/or application of the protocol for birth partners in inpatient postnatal areas.

- A need for improved mental health support for women who are separated from their baby/babies in NICU.
- A significant need for more mental health support for women and families.

Cross-referencing this theme:

Summary	• The birth partner is not always seen as a vital member of the care team. They provide crucial support during pregnancy and birth and in the neonatal period and yet are often excluded and left to deal with any residual trauma alone. Whilst there are limitations as to how much maternity and neonatal staff can achieve, there is a requirement for maternity services overall to modernise and evolve into a much more family (and carer support)-centric environment.
The primary linked themes	• As previously, the birth partner (and exclusion of) is inextricably linked to trauma. • The next most prevalent links are around compassion, communication and being ignored. This is indicative of how birth partners feel and are often observed to be discounted by care staff. • The theme of trust is also prevalent within feedback around birth partners. This is both because they are a trusted advocate for the woman who is using services, but also that the trust of the birth partner is damaged when they are excluded.
Secondary linked themes	• Trauma is significant within this theme. We discuss birth partner trauma within this section of the report. • Environment, food and cleanliness are also issues raised. This could be due to the birth partner spending time in an environment which they are closely observing.
The part of the pathway where this theme is most prevalent	• There is significant prevalence in the postnatal part of the pathway but there is also substantial commentary in the antenatal part of the pathway. • The second key pathway area is in the involvement of neonatal services.
Variances in year or date ranges	• There is no pronounced variation in any year.

The experiences of minority groups

4.135 Ethnic disparities in maternal health are well known. Women who reported their ethnicity as Indian, Pakistani and 'any other White background' reported poorer experiences including not feeling listened to and not receiving help during their antenatal and postnatal care in line with The Equality Act 2010[49].

4.136 The 2021 England and Wales population census showed that the population in Swansea and Neath Port Talbot is mainly White (93.4%), with ethnic minority groups representing 6.6% of the population. This is a lower non-White population proportion than is now typical across the UK.

4.137 For Swansea and Neath Port Talbot, the female population of child-bearing age is predominantly White but there is a higher proportion (8.9%) from non-White ethnic groups

than is typical across Wales (with the exception of Cardiff). The largest non-White broad ethnic minority group is Asian which includes women of Bangladeshi, Indian, Chinese and Pakistani origin. South Asian women are 60% more likely to suffer stillbirth or a neonatal death, and their babies are much more likely to be born preterm. Black women (African and Caribbean) accounted for almost 2% of the female population.

4.138 The 2025 MBRRACE-UK report showed the risk of maternal death among Black women was over twice as high as for White women despite the significant disparity in patient episode numbers. The reasons for these disparities are not fully understood, but differences in the incidence of deprivation, co-morbidities and pre-existing conditions between ethnic groups, and barriers to engagement with health services for some groups are thought to contribute.

4.139 A May 2022 report published by Five X More, set out the experiences reported by 1,340 Black and Black (bi-racial) women in maternity care services, 54% of whom reported facing challenges with healthcare professionals during their maternity care. These were particularly about the standard of care they received during labour and how their concerns were addressed by professionals.

4.140 SBUHB provided ethnicity information for the mothers in the cases reviewed by the clinical review team (stillbirths, neonatal deaths, maternal deaths and admissions to ITU). This indicated that 84% of women were from a White background and 5% were from an Asian background. Information was not available for 11% of women.

4.141 MBRRACE-UK data indicated that White women represented 53% of deliveries over the five years to March 2024; however, this analysis was unreliable as almost half of deliveries did not have this characteristic recorded. This weakness in data collection has also been highlighted in a report by the Maternity Neonatal Safety Support Programme for Wales in 2023.

4.142 Additionally, one in five women experience a mental illness during pregnancy or in the postnatal period. This can lead to barriers such as trauma, stigma and discrimination, alongside challenges with accessing services and good quality care. The 2024 Maternity Survey undertaken by the CQC in England, stated that women with a long-term mental health condition reported poorer experiences around feeling listened to during their antenatal care as well as in the confidence and trust they felt in the staff caring for them during labour and birth. Over the last ten years there has been an increasing focus upon mental health care. In 2022, 85% of women felt they were given enough support for their mental health during their pregnancy; compared with 83% in 2021[50].

4.143 Women with neurodiverse conditions also experience pregnancy and birth in (usually) extreme and enduringly impactful ways. Hypersensitivity to lights, noise, stimulation, touch can exacerbate fear responses, trauma and future aversion to pregnancy and birth.

4.144 Intersectional disadvantage (where one or more factors compound to create a special type of disadvantage) for example, belonging to an ethnic minority group, where English is not the first language, living in poverty, living with a disability or neurodiverse condition, create areas of margin which intersect.

4.145 Through our work we heard many references to the friendliness, compassion and support which midwives showed to women who attended focus groups held with seldom-heard groups. There were multiple references to the quality of care available and some women who had received maternity care in other countries noted the significant positive difference in the care they received at SBUHB.

4.146 There were, however, recurring barriers to women and families from seldom-heard groups reporting an overall positive experience of care as described below.

The need to improve the insight of staff into cultural differences

4.147 Several people noted that staff need to be better supported to understand the cultural practices, expectations and norms of different groups. Examples of what this looks like in practice included:

- Women feeling that they were not given time to get dressed or put on their hijab, thus feeling their respect and dignity were compromised.
- Women in some cultures may nod as a sign of respect rather than to signal their understanding or agreement.
- Post birth cultural norms are not the norms of the western world. For example, some cultures do not bathe post birth, some need to stay warm and do not get out of bed post birth. Three women talked about the norm of having a feast to celebrate the baby's birth but were offered only a small meal (such as a sandwich) post birth.

Addressing bias

4.148 Some women and families felt that the way in which they were spoken to and treated was different because of their appearance. We heard:

- Women feeling that they would receive a better standard of care if they did not wear a hijab.
- Women with White partners sensing that they were treated with more kindness and understanding than if their partner had been non-White.
- Women feeling compelled to be more assertive than they ordinarily would be in order to self-advocate. A comment that illustrated the view of several women we spoke to was that you have to demonstrate "you were aware of your rights."

Being listened to

4.149 Women and families described a lack of information in their language about how their views could be heard by the Health Board.

4.150 Some women told us that they had considered raising a concern about their care but felt that this would be futile. We heard accounts of women waiting over a year before receiving a response. Others shared that they had not been told how to raise a concern or the process of contacting the Ombudsman.

Themes which relate to broader aspects of experience

4.151 As described in the detailed analysis above, there are several other themes which bring forward some distinct areas for learning. They are expressed through the following words:

Bereavement Care

4.152 We heard that some women had excellent experiences of bereavement care, when they were able to access it on a consistent basis; other feedback reflected:

- Very limited time allocated with bereavement midwife due to lack of availability and a high caseload.
- The bereavement midwife works on a part-time basis, and when they are not available, there is no cover in place.
- The experience of the midwife in bereavement really matters. There were positive comments around continuity of care at this stage.
- Families having to 'google' what happens in a postmortem. Postmortem results not being delivered with any context.
- Mortuary staff received positive feedback on the care they showed.
- End of life communications were generally seen as good. A special room was provided, and families were treated with respect and not rushed.

Debrief

4.153 Debrief is more formally discussed in sections 6 and 7 on staffing and governance and is a theme which reaches across most of the domains of this report. Some of the things we heard and understood in terms of debrief included:

- A disconnect between what was promised in terms of debrief and what was delivered.
- Confusion between what is a debrief, what is an investigation and what is a complaint response.
- Women having to continually chase to get answers.
- Staff who are closing cases on the risk management system (Datix) without notifying families of the outcome.

- Quality control on letters is sometimes poor.
- Women and families not knowing if anything has changed as the result of an adverse experience.
- Families not knowing whether they have a right to access a debrief.

Staffing and teamwork

4.154 Section 6 of this report is dedicated to staffing and teamwork, however, in terms of feedback from women and families on experience, we heard:

- Consultants were generally described as poorer at communicating than the midwives.
- Women feeling that they were an inconvenience to staff.
- Staff writing incomplete accounts of the consultation in notes, missing out very relevant details.
- The difference in experience is clear between midwives.
- Accessing the unit during Covid-19 was particularly upsetting because of restrictions and staff were "incredibly hands-off."
- Perceived gaps in the detailed knowledge of staff and women feeling that it increases risk, for example, "when a baby is lying back-to-back, this could cause irregular contractions; this was interpreted as not being in established labour."
- Not answering the call button and "looking irritated" if it is pressed again.
- A busy Postnatal Ward with "staff running around like headless chickens."
- The Labour Ward was described by some as "fantastic" with support from midwives after the birth.
- Women being incorrectly persuaded to stay at home to labour.
- Some women could not make contact with staff on the numbers given.
- Risks were not properly explained.
- The fast action of staff helped to save life.
- Midwives were seen on occasions to act as "amazing advocates" for the women. They were instrumental in helping women to have the birth they wanted.
- The quality of neonatal care was seen as very good.

Breastfeeding

4.155 Breastfeeding was a consistent theme within the feedback with by far the most frequent issue being around a lack of support. Other areas included:

- Midwives not having time to help with breastfeeding as this requires patience and understanding.
- Women feeling forced to 'give-up' and just use a bottle.
- Inaccurate advice given about formula supplementation, nipple shields and pumping breastmilk.
- Training for staff is required in current breastfeeding guidelines.
- Ensuring the postnatal pathway has robust infant feeding elements which all staff should follow.

- Including birth partners in how they can help and support.

4.156 For SBUHB between January 2019 and June 2024, the overall rate of babies breastfed at birth was 65% and this rate has been steadily increasing to over 68% in 2024 (see appendix 7). Increased midwifery capacity is needed in maternity services to further improve support for breastfeeding, and this is recognised by the Health Board.

4.157 The UNICEF UK Baby Friendly Initiative provides support to maternity, neonatal, community and hospital-based children's services to improve the quality of breastfeeding support services; it is recognised as setting the 'gold' standard for breastfeeding. Training for staff in maternity and neonatal care follows this programme. NICU at Singleton Hospital was the first unit in Wales to gain accreditation in 2019 following a doubling of its breastfeeding rates[51].

Environment, food and cleanliness

4.158 There were many comments around environment, and most women mentioned at least one example of their experience in relation to these aspects whilst talking about the clinical care they received. Feedback includes:

- Women who could not be admitted to the right place because of a lack of beds.
- Unable to access clean drinking water.
- Women who struggled to control their bladder and were left in soiled sheets for extended periods.
- Very positive feedback on waterbirth, with the same staff available continuously throughout labour and delivery.
- Given a bed with no pillows or blankets as they had run out.
- Air conditioning unit blowing cold air directly onto newborn baby.
- No cot available for baby when born.
- Food not adjusted for women with gestational diabetes. Halal menu is limited and not culturally sensitive.
- Women reported feeling hungry with no flexibility around the provision of food.

Language

4.159 While some people told us that communication with staff at SBUHB had been facilitated by Language Line (an on-demand interpretation service using live, professional interpreters via video link commonly used in the NHS). We heard that this facility is used "only when absolutely necessary." We heard that Language Line was the first choice of translation services when there were difficult conversations to be had. Language Line did not always meet the needs of women. We heard, for example, of a Mandarin speaker being offered the support of a Cantonese speaker.

4.160 Women were not offered access to a face-to-face interpreter at any stage.

4.161 Written information was not available in an individual's preferred language. Women whose first language was not English were offered information packs that were solely written in English. They did not understand information it contained, such as instructions for making up bottles of milk, or vaccination programmes, because this was in English. Some women used a web browser to translate the information for themselves.

Insight into neonatal experience

4.162 Capturing the experience of families who have used neonatal services has been challenging. Almost all contacts made to the review have been from people wanting to share their experience of maternity services.

4.163 We met the NICU Veterans Group which is made up of parent volunteers who have lived experience of neonatal services at SBUHB. The primary purpose of the group is to support families who have, or who recently have had a baby or babies being cared for in the neonatal unit. Examples of support they offer include signposting families to additional support they may need (such as mental health or bereavement support), directing families to other support services such as temporary accommodation close to the NICU, and being a sounding board for concerns and experiences.

4.164 Feedback from the NICU Veterans Groups highlights several key areas of strength that those present wanted to celebrate:

- **Family Integrated Care (FiCare)** - this is an approach which promotes the engagement of parents in their baby's care. The unit's dedication to FiCare was universally described by those present as a key strength, enabling parents to feel part of the care their baby receives. Implementation of FIC is a real positive and having families as part of the care team is very helpful and makes families feel more in control of a situation; it gives them a voice. For example, families can now tube feed their babies which was not the case in 2015. We were told:

  "FiCare has been the best thing to happen for babies on the unit…you have the opportunity to ask, 'what does that mean?'"

  "It feels more like your baby…you feel confident to do various things."

- **Family support** was highlighted by several people we spoke to. We were told that there is a concerted effort to support families, including the baby's siblings, while using neonatal services. This ranges from access to a family room, accommodation near Singleton Hospital, signposting to support from the Veterans Group and a Facebook group for parents.

4.165 There were, however, areas in which the NICU Veterans Group felt that the experience of families could be further improved, many of which were also echoed by staff (see section 6). We were told:

- Psychological support, including bereavement support, makes a huge difference to families when it is available, but the capacity of such services at SBUHB is significantly stretched. We heard accounts of families who were unable to access emotional and psychological support and sought this from services outside the Health Board.
- Information was described as overwhelming and complex, and we heard accounts of people feeling that the 'learning curve' associated with their baby being admitted to NICU was significant.
- Postnatal support to women who have a baby being cared for in NICU was also noted as an area that could be improved. We heard that women wanting to check that they are healing normally after having a baby was not always easy.

Postnatal trauma in women

4.166 Traumatic birth is defined as 'physical and emotional suffering during birth that resulted from either complications, physical injury or negative reactions during the birthing experience.' Postnatal PTSD involves pervasive, long-standing and overwhelming feelings of anger,

sadness, guilt or shame. People with complex PTSD (CPTSD) can extend into enduring mistrust, and emotional dysregulation[52].

4.167 The UK Birth Trauma Inquiry 2024 highlights the impact of birth trauma on women, parents and families. The inquiry received more than 1,300 submissions from people who had experienced traumatic birth, as well as nearly 100 submissions from maternity professionals. The stories told by parents were harrowing. They included accounts of stillbirth, premature birth, babies born with cerebral palsy caused by oxygen deprivation and life-changing injuries to women as the result of severe tearing. In many of these cases, the trauma was caused by mistakes and failures made before and during labour. Frequently, according to the same report, these errors were covered up by hospitals who frustrated parents' efforts to find answers.

4.168 There were also far too many stories of care that lacked compassion, including women not being listened to when they felt something was wrong, being mocked or shouted at and being denied basic needs such as pain relief. Women frequently felt they were subjected to interventions they had not consented to, and many felt they had not been given enough information to make decisions during birth. The poor quality of postnatal care was an almost universal theme.

4.169 Women reported poorer experiences of care if they had an emergency caesarean section, were younger (aged 16 to 26), or had pelvic health problems or another pregnancy-related condition. Other groups reporting poorer experiences of care included those who had an assisted vaginal delivery and had a planned caesarean section.

4.170 PTSD and CPTSD can evolve over many years and indeed, there are many factors which exacerbate this trauma, including not feeling believed, having to fight for perceived justice and living with the daily consequences of the harm. According to the Birth Trauma Association, there are four main symptoms of postnatal PTSD. These are:

- re-experiencing the traumatic event through flashbacks, nightmares or intrusive memories. These make you feel distressed and panicky;
- avoiding anything that reminds you of the trauma, or an absolute fixation with the trauma, not being able to think of anything else;
- feeling hypervigilant: this means that you are constantly alert, irritable and jumpy. You may worry that something terrible is going to happen to your baby;
- feeling low and unhappy; a woman may feel guilty and blame herself for the traumatic birth. A woman may have difficulty remembering parts of the birth experience.

4.171 A study conducted in 2020 of 222 women reported that 29% described their experience as traumatic (but this has also been reported as up to 40% in other studies) and between 4-6% presented with postnatal PTSD; 15% met the criteria for PTSD. This study placed specific interest in 'obstetric intervention' and postnatal trauma symptoms, finding that 'feeling supported' was the factor which made a significant difference in the postnatal wellbeing of women and postnatal trauma symptoms[53].

4.172 Putting those numbers into context, in a birth unit the size of SBUHB taking over 3,000 births per year that could mean, on a statistically reflective basis only, that more than 1,200 women per year could reasonably describe their birth or parts of their experience as 'traumatic' with up to 180 women going on to present with actual symptoms of PTSD. Statistically on the same basis, between 150-180 birth partners may also exhibit signs of trauma or PTSD from their experiences.

The birth partner and under-acknowledged trauma

4.173 A lesser-known result of birth can be postnatal PTSD or post-traumatic stress disorder for birth partners (PTSD or CPTSD); many birth partners are not aware that this could become a feature of the birth experience, as most are entirely focussed upon the needs of their partner. However, trauma experienced by the birth partner can have an equally damaging impact upon the postpartum experience of a family[54].

4.174 As many as 5% of birthing partners may develop trauma after childbirth but as many as 98% of partners attend the birth in the UK. Birth partner trauma may, therefore, be substantially underrepresented. PTSD symptoms can manifest as much as five years down the line although this is such an underrepresented area of study, it could be much more.

4.175 Many reasons exist for birth partner trauma including feeling helpless whilst witnessing their partner in danger or distress, witnessing their partner haemorrhaging, the baby encountering complications such as being born not breathing, or getting stuck during the journey through the birth canal, inadequate pain relief or seeing extensive amounts of blood.

4.176 It is important that midwives are on the lookout for traumatic childbirth situations and educate partners on what they may experience in the weeks and months afterwards. The lack of understanding, recognition or time which can be allocated by medical professionals in relation to what partners experience both in the moment and after a birth can mean that this important psychological burden remains underdiagnosed and unreported and many birth partners do not access help.

4.177 At SBUHB, it was evident that birth partners (be they dads, partners or other family members) wanted to talk to us about the experiences they had witnessed. In some cases, the experience had left them feeling helpless and traumatised with nowhere to go with their own trauma other than to accompany their partner to the debrief or access services through a GP.

4.178 This issue is not unique to SBUHB; it is a feature increasingly noted across England and Wales. This is not to say necessarily that the birth trauma experienced by birth partners has increased (although it may have), but the recognition of trauma and mental health impacts of post-traumatic stress have certainly increased. In turn, much more family-centred and holistic responses must be mobilised to avoid mental health conditions becoming enduring.

5

5. Review of the clinical care provided

Summary

This review focusses on women who experienced poor perinatal outcomes whilst having their maternity care at SBUHB.

What are the key issues?

Key issues identified include access and admission to the maternity service, with a particular focus on improving the maternity triage system and strengthening the induction of labour (IOL) pathway. There are also specific issues around fetal monitoring, delays in transferring women to the operating theatre, and communication and documentation within the clinical teams.

From a neonatal perspective, the majority of babies where learning was identified were of less than 27 weeks gestation. Common elements included a lack of senior oversight, management of suspected sepsis and inconsistency of care planning and delivery.

Four key issues were identified from the review of maternal admissions to intensive care: recognition of deterioration and the escalation and use of maternity early warning scores (MEWS); provision of enhanced maternal care at Singleton Hospital; provision of outreach maternity-specific critical care at the Morriston site; and the need to ensure incident reviews and complaint responses are timely, independent, and provide opportunities for learning.

What is currently in place?

The Birmingham Symptom Specific Obstetric Triage System (BSOTS) has recently been introduced.

The service has also secured funding to upgrade fetal monitoring capability to ensure that clinicians are supported in identifying abnormalities and in ensuring prompt and timely escalation.

There are both local and network neonatal guidelines, but some of these lack a clearly specified pathway of care.

PROMPT (Practical Obstetric Multi-Professional Training) is undertaken with the multidisciplinary team and has been for some time. Further development of midwives has commenced on the Singleton Hospital site to enhance skills and competencies relating to enhanced maternity care.

What more is there to be done?

A major focus is required on improving the quality of triage and access to the service, in line with UK-wide guidance from the RCOG and RCM. A standardised and single contact triage process should be available for all women.

Clinicians must achieve consistent categorisation of cardiotocography monitoring (CTGs) and adherence to the timeframes for classification of caesarean sections.

Senior clinical staff must have a mandatory presence in operative vaginal deliveries requiring rotational forceps or assisted breech deliveries. Complex caesarean sections must also be attended to by senior clinical staff.

Communication following serious adverse events must be prioritised, and appropriate multidisciplinary review conducted within reasonable timescales.

A robust pathway must be developed to discuss the appropriate care setting for complex pregnancies, in order to plan the optimal timing and place of delivery.

The quality of care given to sick babies needs to be consistent.

There is a need to review and improve the network pathway for the care of babies with suspected or proven surgical complications of prematurity.

Pregnant or recently pregnant women in ITU should have access to a healthcare professional who has enhanced maternal care competencies at all times. Also, all maternity patients admitted to intensive care must have evidence of a clearly documented multidisciplinary consultant-led review at least once every twenty-four hours. The team attending the patient must include both an intensive care consultant and an obstetric consultant and will ideally also include an anaesthetic obstetric consultant and a senior midwife. This should be included in the role and responsibilities of the on-call obstetric team.

What are the immediate priorities?

The immediate priorities must be to improve the quality of triage and access to the service.

The service should ensure that all maternity staff attend the All Wales education programme for the interpretation of fetal heart tracings and have access to cardiograph computerised analysis.

The induction of labour pathway must also be viewed as a priority in order that women do not experience delays with the process, in addition to a need to schedule induction of labour within an appropriate timeframe.

The clinical management of extreme preterm babies, particularly the specific challenges posed by babies of less than 24 weeks gestation ('nano-preterms'[55]), needs immediate review. This should focus on care delivered at SBUHB and within the wider neonatal network.

Senior oversight of management of sick babies needs to be more visible within clinical records. This includes clear documentation of thought processes underpinning decision making.

There is an urgent need to provide a full-time paediatric radiology service or as a minimum a full-time reporting service.

A maternity-specific early warning score (MEWS) should be used for all pregnant and recently pregnant women rather than the National Early Warning Score tool for adults (NEWS2) wherever they are cared for in hospital (either at Singleton or Morriston Hospital).

Introduction

5.1 This review of maternity and neonatal care was commissioned by SBUHB in light of data from the MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Surveillance report. This demonstrated that the Health Board's neonatal mortality rate was more than 5% higher than the average for neonatal intensive care units without neonatal surgery in the UK over several years. MBRRACE-UK recommends that Trusts and Health Boards:

"*Investigate potential modifiable factors in the treatment of neonates when an organisation's stabilised and adjusted neonatal mortality rate falls into the red or amber bands after exclusion of deaths due to congenital anomalies. Ensure that this encompasses both local population characteristics and quality of care provision.*"

5.2 As a key part of the terms of reference, the clinical review team was required to conduct an independent clinical review of the maternity and neonatal care provided at SBUHB. The primary purpose of the clinical review element was to identify organisational learning which would help to improve the quality and safety of maternity and neonatal services now and into

the future and to provide answers, where answers existed, for women and families who had questions or concerns about the care they received.

5.3 The clinical review was not intended to apportion blame, specifically seek out individual deficiencies or focus exclusively on error, omission or poor practice. Any instances of particularly good practice were also captured within each case review.

5.4 This section sets out areas of improvement across both the maternity and neonatal services to ensure care in the future is safe, effective and in line with local and national guidance applicable in Wales.

Methodology

5.5 The clinical review used a multidisciplinary team (MDT) approach. Each case was reviewed independently by all of the reviewers and findings recorded on a standardised review tool. All reviewers (neonatologist, advanced neonatal nurse practitioner, obstetricians, midwives, and, for women who needed treatment in intensive care, an intensivist/anaesthetist) then came together to quality assure and finalise each review and agree modifiable factors and learning.

5.6 Case notes and other documentation were made available electronically. The role of the MDT was to review the clinical notes and any other supporting documentation to determine whether, in their professional opinion:

- the care provided was appropriate in all circumstances;
- any deficiencies in care contributed to adverse outcomes for mothers or babies;
- any previous internal review was of an appropriate standard;
- any learning which emerged was acted upon and reflected in practice; and
- there were any lessons learned (good or bad) which could be used to shape the service going forward.

5.7 There were several cases where women received intensive care after delivery in the Intensive Therapy Unit (ITU) at Morriston Hospital (22 women). These cases were added to the Terms of Reference for the review following a site visit which highlighted that the maternity unit at Singleton Hospital is isolated in such cases. The care these 22 women received was reviewed by a separate obstetric, maternity and anaesthetic team ('the ITU review team'). 10 of the cases involved neonatal care, which were reviewed by the same neonatal review team. To ensure the quality of the reviews across all cohorts was of a similar standard, the same review tools and method were used. Once the ITU review team and neonatal review team had completed these case reviews, they were then jointly reviewed with both maternity review teams and the neonatal team to agree findings.

5.8 The standardised review tool supported assessment of the care of the mother during pregnancy and birth in twelve areas which are set out in Table 1.

Table 1: Areas of maternity care assessed

1. Pre-pregnancy care	2. Assessment and point of entry to care
3. Diagnosis and recognition of high-risk status	4. Referral to a specialist
5. Treatment	6. Clinical leadership

7. Education, knowledge and training	8. Documentation
9. Discharge or transfer from care	10. Communication
11. Policies and procedures	12. Women and family

5.9 There is a degree of continuity in the provision of maternity and neonatal care, particularly in terms of effective clinical leadership and the need to follow appropriate policies and procedures. However, there are also areas which are different and some which are specific to neonatal care. For that reason, the neonatal care provided to the baby was assessed in a different but complementary set of areas which are detailed in Table 2.

Table 2: Areas of neonatal care assessed

1. Supporting transition and resuscitation	2. Stabilisation and transfer to the neonatal unit
3. Admission and first hours	4. Ongoing treatment
5. Referral	6. Discharge or transfer from care
7. Clinical leadership	8. Education, knowledge and training
9. Documentation	10. Communication
11. Policies and procedures	12. Family

5.10 Where applicable, care was assessed against contemporaneous clinical practice guidelines or standards expected of health professionals.

5.11 All families having their care reviewed were contacted to inform them the review was taking place. At this time, families were asked if they would like to share their story, or if they had any questions they would like answered during the review. The response to this was limited, meaning the review team were unable to see the impact of the clinical care on the family from their perspective in most cases.

5.12 Direct communication with a number of families who have asked for feedback from the review of their care would suggest that there are additional areas of learning, particularly concerning a lack of kindness and compassion from staff, and women and families feeling not listened to when raising concerns (see section 4).

Assessment Criteria

5.13 Where the care and treatment provided were found to have fallen below the standards expected, the review team recorded this as a 'modifiable factor' (MF). Modifiable factors are events (or interventions) in care, which, had they been done differently, may have made a difference to that care outcome.

5.14 Each MF was then assessed to determine the extent to which it may have had an adverse impact on the outcome for mothers and babies. Each of the MFs was then given one of three classifications as follows:

- Wider Learning.
- Minor.
- Major.
- Where no issues were identified with the care provided, this was categorised as 'No MFs.'

5.15 Given that the quality of the care provided to mothers might subsequently have had an impact on the outcome for their babies, by necessity, the definitions for MFs used to assess the maternal and neonatal elements of each review differ slightly. These differences (Table 3) may appear subtle, but they are significant, particularly in terms of the inference which can be drawn about the relationship between the care provided and the outcome which followed.

Table 3: Definitions of Modifiable Factors

Modifiable factors	Maternal definitions	Neonatal definitions
None	No issues with care identified.	No issues with care identified.
Wider learning	Although lessons can be learned, the issue did not affect the overall outcome.	Care issues identified which would have made no difference to the outcome for the baby.
Minor	The issue was a contributory factor, but different management would have been unlikely to change the overall outcome.	Care issues identified which may have made a difference to the outcome for the baby.
Major	The issue contributed significantly to the poor outcome. Different management may have altered the outcome.	Care issues identified which were likely to have made a difference to the outcome for the baby.

5.16 It is important to emphasise that the use of the terms 'minor' or 'wider learning' in these categorisations is not intended to minimise the significance of the issues, nor should it be seen to disregard the impact that these issues may have had on the experience of mothers, babies and their families. Instead, it seeks to make clear the extent to which, in the professional opinion of the review team, each modifiable factor influenced the overall outcome.

Review cohorts

5.17 The review cohort (excluding women who were treated in intensive care) comprised 77 pregnancies (81 babies) reported to MBRRACE-UK 2020-22 inclusive, with the addition of all babies who died beyond 28 days (post neonatal deaths) in 2022 (3 babies). In addition, to determine the safety and effectiveness of the wider care provided by the perinatal service, the clinical review team assessed the maternal and neonatal care in the most recent calendar year for which all information was available (2022) for an additional 74 babies and their mothers, based on the following criteria:

- all babies who received therapeutic hypothermia for presumed hypoxic-ischaemic encephalopathy (HIE);
- all babies transferred out for intensive or high dependency care; and
- all term babies who received intensive care.

5.18 At the outset there were 151 episodes of care for review; however, 2 of those cases did not fit the review criteria so were removed, and 2 cases were moved into the ITU review (see further below).

5.19 From the remaining 147, 33 (22%) booked and birthed at another Health Board with babies transferred following birth to SBUHB for neonatal care. As the remit of the review was to review care provided at SBUHB only, there was no maternity review of these cases. From the 147, 20 (14%) had booked with another Health Board but required transfer to SBUHB for further care and birth.

5.20 The analysis and conclusions which follow are therefore based upon the information obtained from the clinical review of the care provided to 114 women and 113 babies who **received neonatal care**.

5.21 The total number of babies who received neonatal care was made up of 39 neonatal deaths and 74 neonatal unit (NNU) admissions who received care in 2022 and met the criteria set out in the Terms of Reference for the review. Across the neonatal deaths 61% were male. The number of cases reviewed in each of the years is shown in Table 4 and the gestational age distribution of the babies is detailed in Table 5.

Table 4: Number of cases reviewed

Year	Cohort	Total Pregnancies reviewed	Babies (SB & NND)	Stillbirths (SB)	Neonatal Deaths (inborn)
2020	Reported to MBRRACE-UK	21	25	16	9 (6)
2021	Reported to MBRRACE-UK	27*	29	11	18 (15)
2022	Reported to MBRRACE-UK and babies who died >28 days	21*	27	15	12 (8)
Sub-total		**69***	**81**	**42**	**39 (29)**
2022	Additional cases	45	74	n/a	0
Total		**114**	**155**	**42**	**39**

** One set of twins was born across December 31st/January 1st; their deaths are reported in the MBRRACE-UK cohorts for separate years.*

Table 5: Gestational age distribution of babies reviewed

Gestational age (weeks)	Number of babies			
	Notified to MBRRACE-UK and post-neonatal deaths 2022			Additional cases 2022
	2020	2021	2022	
22-24	4	6	7	2
25-27	3	3	2	2
28-31	1	3	1	6
32-36	0	3	0	4
>37	1	3	2	60
Total	**9**	**18**	**12**	**74**

5.22 The recorded cause of death in the 39 neonatal deaths was reviewed for themes. The most common stated primary cause of death was extreme prematurity (14 babies), associated with severe pulmonary disease in 6 babies and sepsis in 3. The second commonest cause of death was HIE (9 babies), of whom 3 were born within SBUHB and 6 who were transferred in for their treatment from other hospitals in the region. Respiratory disease was stated as the primary cause of death in 5 babies and sepsis in a further 3 babies.

Self-Referrals

5.23 In addition to the cases described above, there were a total of 4 families out of 25 self-referrals who required a multidisciplinary review of their care. Two of the self-referred cases required review by the maternal ITU team, given the circumstances of the perinatal care. The MFs identified in the one case reviewed by the maternity and neonatal team identified minor modifiable factors and wider learning. Two of these required neonatal care to be reviewed. Reviews were undertaken using the same methods used in all other cases. The modifiable factors identified in the care of the babies were wider learning, and were in the same domains as the rest of the cases above.

ITU cases

5.24 There were 22 cases of maternal admission to ITU at Morriston Hospital in the review cohort (including two self-referrals).

Key Findings

Overview

5.25 Overall, the maternity and neonatal teams have positively engaged with the clinical review team and have been keen to understand any emerging areas of learning from the case reviews to implement improvements at the earliest opportunity.

5.26 The clinical review team had the opportunity to meet the maternity and neonatal teams on site at Singleton Hospital prior to the case reviews commencing. The maternity team were able to walk the review team through the patient journey and identified areas they were proud of and areas of challenge to the running of the service.

5.27 The neonatal team shared their ongoing quality improvement initiatives during the visit and assisted the review team in understanding the realities of how the neonatal service runs in practice. The team shared, at this time, what they felt were the limitations of the current neonatal network and the impact that the Covid-19 pandemic had had on areas of multidisciplinary team working, including liaison with Infection Control.

5.28 This face-to-face visit across the maternity and neonatal service provided useful context to the review team. Subsequent meetings during the review process facilitated early sharing and discussion of themes emerging from the case reviews.

5.29 The analysis and conclusions which follow are based upon the information obtained from the clinical review of the care provided to 114 women and 113 babies who received neonatal care.

5.30 The review looked for areas of learning from each case review, but also areas of good practice to highlight. In maternity there were instances of good practice in the following areas:

- the timely management of disseminated intravascular coagulation (DIC);
- early involvement of the anaesthetic team in high risk cases;
- use of cell salvage;
- early referrals to the appropriate support services; and
- support from the bereavement team following baby loss.

5.31 In the neonatal service the following were noted to be positive areas of practice in some cases:

- an established link with the palliative care service for early parallel planning and support for the family and neonatal team;
- evidence of a move to family integrated care principles;
- evidence of occupational therapy availability and psychology support on the neonatal unit; and
- a timely process for obtaining a second opinion on computed tomography (CT) and magnetic resonance imaging (MRI) scan interpretation to support clinical decision making.

5.32 The clinical review team identified a significant number of inconsistencies in the quality and effectiveness of the care provided across both services. Multiple areas of learning were identified, some of which were seen to improve from the cases reviewed from 2020 compared to those from 2022, but others which did not improve.

Obstetric and midwifery modifiable factors (MFs)

5.33 The reviews of the maternity care provided to the 114 women from 2020 to 2022 identified 337 separate MFs. Of these:

- 12 were major MFs in 8 women within the cohort of 114 women (11%);
- 27 were minor MFs in 21 women within the cohort of 114 women (24%); and
- 298 were identified opportunities for wider learning across 114 women.

5.34 The review team noted that the numbers of major and minor MFs reduced during the years assessed:

- in the 2020 MBRRACE-UK cohort, 8 categories had no major MFs;
- in the 2021 MBRRACE-UK cohort, 9 categories had no major MFs;
- in the 2022 MBRRACE-UK cohort 11 categories had no major MF; and
- in the 2022 extended criteria cohort, there were no major MFs.

5.35 In 93 women, no major or minor MFs were found, but there were 102 opportunities for wider learning. This represents 34% of the total wider learning MFs. The main categories identified by the reviewers were education, documentation, referral to specialist, communication, policy and procedures, clinical leadership and woman and her family.

5.36 The full tables detailing all of the above categories are found below with the notable themes from the case reviews and the identified modifiable factors also summarised below.

Table 6: Obstetric/midwifery modifiable factors MBRRACE-UK 2020 (cohort = 21 women)

Modifiable factor (MF)	Wider learning	Minor	Major
Pre-pregnancy or preconception care	0	0	0
Assessment or point of entry to care	1	3	2
Diagnosis or in the recognition of high-risk status	1	1	1
Referral to a specialist	0	0	0
Treatment	4	3	3
Clinical leadership	0	0	0

Education, knowledge and training	2	0	0
Documentation	12	0	0
Discharge or transfer from care	0	0	0
Communication	15	0	0
Policy and procedures	19	0	1
Woman and her family	0	0	0
Total (no. of MFs)	**54**	**7**	**7**

Table 7: Obstetric/midwifery modifiable factors MBRRACE-UK 2021 (cohort = 27 women)

Modifiable factor (MF)	Wider learning	Minor	Major
Pre-pregnancy or preconception care	0	0	0
Assessment or point of entry to care	5	0	0
Diagnosis or in the recognition of high-risk status	3	0	0
Referral to a specialist	2	1	0
Treatment	3	2	2
Clinical leadership	0	0	1
Education, knowledge and training	3	1	0
Documentation	18	0	0
Discharge or transfer from care	0	0	0
Communication	10	0	0
Policy and procedures	21	1	1
Woman and her family	0	1	0
Total (no. of MFs)	**65**	**6**	**4**

Table 8: Obstetric/midwifery modifiable factors MBRRACE-UK 2022 and Post-Neonatal Deaths (cohort = 21 women)

Modifiable factor (MF)	Wider learning	Minor	Major
Pre-pregnancy or preconception care	0	0	0
Assessment or point of entry to care	1	1	0
Diagnosis or in the recognition of high-risk status	0	2	0
Referral to a specialist	1	0	0
Treatment	2	1	0
Clinical leadership	1	0	0
Education, knowledge and training	4	0	0
Documentation	8	0	0
Discharge or transfer from care	2	0	0
Communication	15	0	0
Policy and procedures	18	0	1

Woman and her family	0	0	0
Total (no. of MFs)	**52**	**4**	**1**

Table 9: Obstetric/midwifery modifiable factors 2022 - Additional Cases (cohort = 45 women)

Modifiable factor (MF)	Wider learning	Minor	Major
Pre-pregnancy or preconception care	0	0	0
Assessment or point of entry to care	1	0	0
Diagnosis or in the recognition of high-risk status	6	4	0
Referral to a specialist	4	1	0
Treatment	14	3	0
Clinical leadership	2	0	0
Education, knowledge and training	5	0	0
Documentation	34	1	0
Discharge or transfer from care	0	0	0
Communication	11	0	0
Policy and procedures	44	1	0
Woman and her family	6	0	0
Total (no. of MFs)	**127**	**10**	**0**

Obstetric and midwifery themes

5.37 There are a number of themes identified within minor and major MF categories which include:

- the recognition of the issues around access/admission to the service;
- missed opportunities to ensure women are in the most appropriate place for their clinical condition;
- delay in induction of labour (IOL) – when there is not always evidence of appropriate risk assessment; and
- delay and recognising abnormal observations of women and/or baby.

Summary of obstetric and midwifery major and minor modifiable factors

There were 12 major modifiable factors in 8 women

In 4 of those cases there were 2 major MFs while the remaining 4 had 1 major MF.

There were 5 major MFs under **Treatment**:

- Failure to act on a suspicious CTG.
- Failure to act on decreased fetal movements (DFMs).
- Lack of a comprehensive written plan around delivery/lack of communication with colleagues.
- Incorrect risk assessment.
- Delay in timing of intervention.

There were 3 major MFs under **Policies and Procedures**:

- In 2 of these cases there was no capacity within the service to do growth scans on a particular group of high-risk women.
- Duplicate guidelines led to failure to act on a history of DFMs.

There were 2 major MFs under **Assessment/Point of Entry**:

- In both of those cases there was delay in review/admission to hospital when contacting the service despite multiple phone calls.

There was one major MFs under **Diagnosis/Recognition of High-Risk Status**:

- Missed opportunity to transfer to consultant-led delivery unit from the antenatal ward when maternal observations were abnormal.

There was one major MF under **Clinical Leadership**:

- There was a lack of senior clinical oversight out of hours.

There were 28 minor modifiable factors in 21 women.

In the **Treatment** category there were occasions where there were:

- Significant delays in commencing or continuing with IOL due to ward acuity.
- Missed opportunities to schedule earlier IOL given the clinical picture.
- Missed opportunities to deliver sooner when the condition of the baby's heart rate was difficult to interpret.
- Caesarean sections not always undertaken within designated time frame.
- Inappropriate classification of caesarean section leading to a delay in delivery.

In the **Diagnosis or Recognition of High-Risk Status** category:

- Incorrect classification of CTG on admission.
- Delay in recognising a CTG abnormality.
- Delay in recognising and acting on abnormal observations.
- Delay in senior review.
- Monoamniotic twins - no evidence of tertiary referral.

In the **Assessment/Point of Entry** category:

- Delay in review/admission to hospital when contacting Antenatal Triage – breakdown in communication between the women and the service.
- Failure to offer preventative treatment for smoking cessation.
- Failure to carry out full risk assessment at booking, resulting in a woman being on the wrong clinical pathway.

5.38 In all cases where the reviewers found major modifiable factors in obstetric/midwifery care, SBUHB had, through their own internal review process, identified similar findings and had already informed families of their findings.

5.39 Reassuringly, the majority of MFs were wider learning. There were some areas where clear themes emerged, and these are highlighted below with their frequency of occurrence. Where there were no obvious themes, we have simply listed the MFs for consideration. While they did not influence the final outcome, they may have had an impact on the overall experience of the women and family.

Policies and procedures

5.40 The area with the greatest number of wider learning factors was policies and procedures.

5.41 There is clear guidance applicable across the UK to support good quality medicines prescribing, to reduce medication errors.[56] [57] [58] There were numerous issues with the standards of prescribing across the majority of the case reviews when reviewed against applicable guidance. Prescribing issues included:

- Use of the term 'STAT' instead of stating time for drug administration.
- Lack of capitals.
- Lack of designation of prescriber.
- 'Crossings off' not signed and dated.
- Spelling errors.

5.42 Other issues identified:

- We identified significant delays in receiving postmortem reports.
- In a number of cases the correct processes following stillbirth and neonatal death were not clearly understood, when occurring overnight or at weekends.
- In a small number of cases the heart rate of the baby was not listened to before undertaking further assessment.
- In a small number of cases resuscitation equipment was not prepared in advance.

Documentation

5.43 There were a number of recurrent themes arising in relation to documentation, relating to practices which are not in line with NHS standards for documentation. Issues identified include:

- Lack of consistent recording of number of pregnancies and disparity in gestation throughout the multidisciplinary records.
- No use of a partogram for women experiencing stillbirth.
- Illegible writing in records.
- 'Crossings out' in notes – which are not then countersigned.
- Staff using first names rather than full names and designation of colleagues.
- Summary of labour not completed.
- Lack of consistent documentation when describing twin pregnancies.

Communication

5.44 There were a number of recurrent themes arising in relation to communication:

- There were a small number of occasions where there appeared to be a lack of communication between the midwifery and neonatal teams regarding neonatal support required at delivery.
- There were some occasions where there was either a lack of, or delay, in communicating the offer of a postnatal debrief to parents.
- There were two occasions when there was a lack of communication between departments in relation to safeguarding issues.

Treatment

5.45 There were a number of recurrent themes arising in relation to treatment including:

- Delays in starting or continuing IOL due to activity on the unit.
- Emergency caesarean sections were not always undertaken in the planned timeframe.
- Delays in administering antibiotics when commencing the sepsis pathway.
- Delays in suturing following normal or instrumental vaginal delivery.
- No overall categorisation of CTG.
- Lack of notations on CTG.
- Lack of awareness of the content of guidelines relating to labouring in water.

Perinatal themes

5.46 There were key areas across both maternity and neonatal care where modifiable factors were influenced by both disciplines. These represented many of the modifiable factors in both communication and documentation for both services.

5.47 These findings are shared below as perinatal themes where there is a need for the services to work together to ensure an improved experience for women, babies and their families whilst receiving treatment at SBUHB, and following discharge.

Communication

5.48 The interface between maternity and neonatal services is key to providing seamless perinatal care. Whilst this appeared to be so in most of the cases reviewed, there were instances where it appeared that neonatal staff arrived at the time of, or after delivery, of extreme preterm babies. The reason for this timing was unclear from the case notes.

5.49 The optimal experience for families after a neonatal journey should include the opportunity for a joint debrief - with maternity and neonatal services coming together to meet families and answer any questions they may have as a joint service. There was no evidence of this being the case; and often, when invited back to meet with one service, the families had to ask at this time to meet with the other service.

5.50 Across both maternity and neonatal services, the quality of the letters sent to families after leaving maternity and neonatal services was not of the expected standard, with language inappropriate for families. They were not always easy to understand and were often impersonal and lacking in compassion.

5.51 Letters regarding investigation of poor outcomes or complaints were not timely, with waits of up to two years. The letters also often lacked detail of any learning that had been identified from internal case reviews, even if a formal complaint had been made.

Documentation

5.52 Details around resuscitation were sometimes inconsistent between midwifery and neonatal notes and may represent a lack of discussion between the teams following neonatal involvement at a birth. There were also discrepancies in key resuscitation metrics recorded by different members of the neonatal team.

Local review

5.53 Importantly, there appeared to be no review of care as an MDT. Maternity care was reviewed separately from neonatal care with an inherent risk of missing vital learning relevant to the entire perinatal team.

5.54 Not all serious incident reports were available for review. It was unclear if these were not completed or not shared with the review team.

5.55 There were instances of clinical incidents noted within case notes, for example drug errors, incidence of extravasation and equipment failures. However, it was unclear whether these had been reported as an incident and any learning noted from subsequent investigation. In addition, where applicable, it was not clear whether statutory Duty of Candour had been completed in line with established procedures[59].

5.56 Local Neonatal Morbidity and Mortality (M&M) meetings did not appear to identify the breadth of learning identified within this review. This may have been captured in discussions, but the learning documented from these reviews is limited, and this means this learning is not shared beyond those present in the M&M meeting. Reviews appeared to occur separately for the maternity and neonatal care, demonstrating a lack of services working together to ensure all learning from cases is identified and shared.

5.57 Where consent for postmortem examination was given, there were long delays before families received results. Whilst outside the Terms of Reference of the clinical review, this delay is likely to adversely impact on families and reduce the opportunities for healthcare professionals to maximise learning from perinatal deaths.

5.58 In general, there was a lack of external involvement in reviews which would provide a 'fresh pair of eyes' to the review of the care and to offer robust challenge where complacency or 'group think' in service provision exists. Clearly the Covid-19 pandemic played a role in this issue but remote attendance by an external clinician might have been possible.

Neonatal modifiable factors

5.59 The reviews of the neonatal care provided to the 113 babies identified 757 separate MFs. Of these:

- 1 was a major modifiable factor;
- 37 were minor MFs across 29 babies (26% of total babies); and
- opportunities for wider learning were identified in the care of all babies reviewed.

5.60 36 babies were notified to MBRRACE-UK during 2020-2022, and a further 3 died after more than 28 days on the neonatal unit in 2022, thus, the total neonatal deaths reviewed was 39.

5.61 24 of this group (62%) were babies of less than 27 weeks' gestation which often represent the most complex babies cared for by neonatal services. Just over half (20/39) of the neonatal death cases had at least one minor MF identified. 15 of these 20 cases (75%) were babies of less than 27 weeks' gestation, one of whom also had the single major MF identified.

5.62 Within the cohort of 74 additional babies reviewed for 2022, 9 (12%) had at least one minor MF identified. Within this cohort, there were 3 babies of less than 26 weeks' gestation.

5.63 The depth of the review process resulted in the identification of many more MFs graded 'wider learning' compared to the numbers graded 'major' or 'minor.' This should be seen as a positive and is the value of robust 'fresh eyes' review. A good quality review undertaken internally in any service is likely to identify some learning. Given the depth of the review process used for these cases, the number of wider learning MFs identified is therefore unsurprising. The review team consider that wider learning identified is a sign of a thorough review and should be viewed positively. It should also be recognised that wider learning MFs related to, for example documentation, are likely to be identified in multiple cases, increasing the overall total of MFs.

5.64 The full tables detailing all of the above categories are found below with the notable themes from the case reviews and the identified modifiable factors also summarised below.

Table 10: Neonatal modifiable factors MBRRACE-UK 2020 (cohort = 9 babies)

Modifiable factor (MF)	Wider learning	Minor	Major
Supporting transition and resuscitation	4	0	0
Stabilisation and transfer to NNU	5	0	0
Admission and first hours	7	1	0
Ongoing treatment	5	3	0
Referral	1	0	0
Clinical leadership	8	0	0
Education, knowledge and training	8	0	0
Documentation	8	0	0
Discharge or transfer from care	0	0	0
Communication	7	0	0
Policy and procedures	8	0	0
Family	1	0	0
Total (no. of MFs)	**62**	**4**	**0**

Table 11: Neonatal modifiable factors MBRRACE-UK 2021 (cohort = 18 babies)

Modifiable factor (MF)	Wider learning	Minor	Major
Supporting transition and resuscitation	12	0	0
Stabilisation and transfer to NICU	12	0	0
Admission and first hours	13	2	0
Ongoing treatment	8	5	1
Referral	0	0	0
Clinical leadership	14	1	0
Education, knowledge and training	12	2	0
Documentation	18	0	0
Discharge or transfer from care	0	0	0
Communication	12	0	0
Policy and procedures	16	0	0
Family	1	0	0
Total (no. of MFs)	**118**	**10**	**1**

Table 12: Neonatal modifiable factors MBRRACE-UK 2022 and Post-Neonatal Deaths (cohort = 12 babies)

Modifiable factor (MF)	Wider learning	Minor	Major
Supporting transition and resuscitation	2	3	0

Stabilisation and transfer to NNU	6	1	0
Admission and first hours	7	2	0
Ongoing treatment	5	5	0
Referral	2	0	0
Clinical leadership	9	0	0
Education, knowledge and training	8	1	0
Documentation	12	0	0
Discharge or transfer from care	0	0	0
Communication	6	0	0
Policy and procedures	12	0	0
Family	1	0	0
Total (no. of MFs)	**70**	**12**	**0**

Table 13: Neonatal modifiable factors 2022 - Additional Cases (cohort = 74 babies)

Modifiable factor (MF)	Wider learning	Minor	Major
Supporting transition and resuscitation	29	1	0
Stabilisation and transfer to NNU	38	0	0
Admission and first hours	62	2	0
Ongoing treatment	50	7	0
Referral	1	0	0
Clinical leadership	48	1	0
Education, knowledge and training	29	0	0
Documentation	73	0	0
Discharge or transfer from care	0	0	0
Communication	61	0	0
Policy and procedures	74	0	0
Family	4	0	0
Total (no. of MFs)	**469**	**11**	**0**

Summary of neonatal major and minor modifiable factors

There was 1 major modifiable factor across all babies reviewed.

- The recognition and management of sepsis has been identified as a theme across a number of cases.
- In one case the review team felt there was significant delay in recognising early signs of sepsis in a preterm baby. In addition, when sepsis was then suspected there was a delay in giving antibiotics, despite clear signs the baby was significantly compromised by infection. The baby died shortly after treatment commenced; and, after death, the baby was found to have a positive blood culture.

- The review team felt the delay in treating infection, despite clear signs, contributed to the death and therefore this was graded as a major modifiable factor.

There were 37 minor modifiable factors identified across 29 babies

Most related to clinical care undertaken on the delivery suite and within the neonatal unit (NNU).

There were no clear themes across the entire group. There were however some common elements including:

- Lack of senior oversight: decisions made in these cases indicated senior support was not available.
- Management of suspected sepsis.
- Delay in initiating blood transfusion in an acute setting.
- Acute equipment availability.

Neonatal wider learning themes

5.65 The themes of the findings are presented in line with the areas of MFs set out below. These relate initially to the order of an infant's 'journey' through the neonatal service and are then followed by those modifiable factors common to all of the former stages.

- In general, temperature management during resuscitation was a clear focus for the neonatal team, with temperature monitoring and checks before transfer to the neonatal unit. In some cases, particularly where there was prolonged resuscitation on delivery suite, babies were found to become cold.
- Availability of working resuscitation equipment is vital for effective stabilisation and resuscitation of sick newborn babies. On more than one occasion there were issues with availability or operability of required equipment.
- In a number of cases, babies were moved from the delivery suite to NNU before it was clear that their airway was fully stabilised. This led to babies being transferred in very high levels of oxygen and deteriorating further on the way to the NNU.

Stabilisation and transfer to NNU

5.66 There was a lack of clinical notes regarding the care required and the condition of infants during transfer from delivery suite to NNU. On a number of occasions infants arrived on the NNU in poor condition, and it was unclear whether the infant had deteriorated during transfer, or if transfer had been initiated before the infant had been adequately stabilised.

Admission and first hours

5.67 Use of antibiotics for suspected sepsis is common in neonatal practice. Antibiotics should be administered as soon as possible and within one hour of the decision to treat (NICE guideline NG195); this was not always the case.

5.68 Decisions regarding antibiotic treatment in preterm babies where sepsis is suspected were not in line with NICE guidance (NICE CG 195[60]). Local guidance sets out a quality improvement project associated with antibiotics decision making for infants of more than 30 weeks' gestation but in multiple cases these criteria were used for infants of less than 30 weeks' gestation.

5.69 Thermal management is a key aspect of neonatal care: both hypo- and hyperthermia are associated with adverse outcomes. Whilst the majority of the infants reviewed had admission temperatures within the normal range, there were numerous instances of infants becoming cold following admission. This was associated with invasive procedures such as insertion of umbilical catheters. In some cases, hypothermia persisted for a number of hours and particularly in cases of extreme preterm infants, thermal management appeared problematic.

5.70 Despite temperature challenges when handled for procedures in the first hours after admission there was no evidence of the clinical team rationalising procedures to avoid overhandling and acknowledging the impact of this.

5.71 In multiple cases a formal admission examination of a baby was not undertaken within the first 1-2 hours of admission as would be expected. The examination was often poorly documented or documented retrospectively.

5.72 In a number of cases of critically ill, extreme preterm infants, the seniority of those undertaking procedures was not felt to be appropriate.

On-going treatment

5.73 There were several areas of ongoing treatment with multiple elements of learning identified.

Procedures

- There was evidence of task-focussed care seen with multiple attempts to establish arterial access in some infants in a variety of sites, when perhaps a less invasive approach might have sufficed.
- Urinary catheters were used frequently (with one instance of a urethral injury), when a less invasive approach might have been considered. There was also a lack of rationalisation and removal of catheters at the earliest opportunity.
- Many of the plain X-ray images reviewed were noted to be rotated, impairing assessment of the clinical questions being raised.

Ventilation strategies

- Hyperinflation was seen on numerous X-rays early in a baby's neonatal course without documented recognition and action to address this.
- There were multiple short trials of iNO (inhaled nitric oxide therapy) and HFOV (high frequency oscillatory ventilation) without a clearly documented rationale for starting or stopping.
- The review team noted numerous episodes of hypocarbia where changes in ventilation and follow-up blood gases were delayed.
- Some endotracheal tubes were upsized without consideration of potential airway trauma.

Fluid Management

- The use of water for injection as a proportion of total infusate is not aligned with the current evidence-base associated with fluid and electrolyte management in extreme preterm babies.
- There were many cases where repeated corrections of calcium and magnesium were undertaken for minimally reduced levels without consideration of potential adverse effects.

- There was an inconsistent approach to fluid management, with a lack of documented rationale, at times resulting in iatrogenic low blood sugar or fluid overload.

Sepsis Management

- Across most cases there was little or no documented discussion with infection control/microbiology colleagues to support rationalisation and treatment choice in antibiotic management.
- In several cases the choice of antibiotic treatment in the presence of in-dwelling central lines or suspicion of Necrotising Enterocolitis (NEC) was not in line with local guidance.
- Management of fungal infection was not always aligned to local guidance in respect to identification of risk factors and clinical indicators as well as decisions around treatment when fungal infection was suspected (e.g. continuing antifungals used for prophylaxis at a therapeutic dose in the presence of confirmed fungal infection).

Central line management

- There was inconsistent documentation and interpretation of line tip position.
- There was consistent acceptance of central line position out with guidance applicable across the UK[61], with no clearly documented rationale for use of lines in suboptimal positions. Sub-optimally placed lines were often not reviewed, and their use rationalised for several days.
- Apparent lack of senior clinician oversight of line insertion/positioning with multiple occurrences of procedural notes around line position inconsistent and not signed off by a consultant.
- Multiple instances of peripheral arterial access which failed to work for more than a few hours. The lines were associated with an almost complete lack of documentation of cannula gauge or clear procedural notes regarding both insertion and removal.

Inotrope management

- Lack of documented rationale for choice of inotrope and review/rationalisation of treatment.
- Inconsistent approach to management of hypotension across the neonatal team.

Blood sugar management

- Management of hyperglycaemia was inconsistent, with varying approaches, often not in line with local guidance. There was a focus on reducing glucose intake over the use of insulin for prolonged periods.
- Management of hypoglycaemia was often inconsistent and not always in line with the local policy particularly around the use of 24% dextrose and no apparent consideration of glucagon.

Clinical leadership

- There was a lack of documented consultant presence in several cases.
- In several complex cases there appeared to be limited senior leadership. As a result, the oversight of and rationale for clinical decision making were unclear.
- Multiple senior clinicians were involved over short periods of time, resulting in inconsistent management.

- There was a lack of oversight and 'helicopter view' of treatment plans and decisions, particularly in complex cases.
- There was a lack of reflective notes of progress and proposed plans in complex cases.

Education, knowledge and training

5.74 In a small number of cases the review team felt that the neonatal team would benefit from focussed MDT simulation to develop skills and knowledge in areas such as hyperglycaemia and fluid management, particularly for the nano-preterm, sepsis management and X-ray interpretation. The latter is clearly important in terms of acute clinical events and is further complicated by the current lack of a full-time paediatric radiology service.

Documentation

5.75 Modifiable factors relating to documentation were identified in several areas of the care pathway. Standards of documentation varied from case to case but included a lack of clear logical documentation with a rationale for clinical decision making. Issues noted within documentation included:

- Lack of contemporaneous documentation, with multiple examples of retrospective notes entries from across the MDT.
- In a number of cases, it was difficult to track who was present at delivery and the role/interventions they undertook.
- Scribe notes or additional sheets without patient identifiers or signatures.
- Lack of documented decision making between ward rounds making it difficult to track clinical decision making.
- Lack of documentation of ward rounds outwith the morning round.
- Quality and accuracy of Badgernet entries seen on admission and discharge summaries.
- Nursing documentation often duplicated entries in the medical notes and often recorded ventilatory settings and blood gas results.
- Multiple examples of illegibility.
- Entries not dated, timed or signed. with a lack of patient demographics on multiple pages of the case notes.

Policy and Procedures

5.76 There is clear guidance applicable across the UK to support good quality medicines prescribing to reduce medication errors. There were numerous issues with the standards of prescribing across most of the case reviews when reviewed against applicable guidance. Prescribing issues included:

- Use of proprietary rather than generic drug names.
- Use of the term 'STAT' instead of stating time for drug administration.
- Use of the term 'double strength' without the prescription being clear what this meant.
- No drug strength specified on infusions.
- A lack of prescribing for drugs given during resuscitation on delivery suite or NNU.
- Lack of capitals.
- Lack of designation of prescriber.

- ‘Crossings off’ not signed and dated.
- Spelling errors.
- Lack of consistent following of local guidelines.

Communication

5.77 MFs relating to communication were also identified in several of in several areas of the care pathway. There were instances of good communication both between professionals and between the MDT and families.

5.78 The impact of a neonatal admission on a family cannot and should not be underestimated. Supporting the whole family as part of a baby’s care is an expectation of neonatal services; however, this was not evident in all of the reviews undertaken. Communication was at best inconsistent; in other instances, it was poor. Separation of a family from their baby may have long-lasting consequences and this must be recognised and avoided wherever possible. Issues noted within communication included:

- Lack of appropriate parent-friendly terminology within some documentation.
- Lack of detail regarding discussions with families to help following clinicians in ongoing conversations and to record what families understood around what they were told.
- Lack of parent questions included within Perinatal Mortality Review Tool (PMRT)/neonatal death reviews as per national recommendations.

Neonatal additional findings

Neonatal unit activity and occupancy

5.79 In accordance with the Terms of Reference, this review was not concerned primarily with the wider aspects of the neonatal service outside of the cases reviewed. It was apparent from the clinical notes that, at times of high acuity on the unit, this impacted specifically on the ability to provide contemporaneous documentation but may have had further influence on the availability of expert clinical care.

Liaison with paediatric specialities

5.80 Cases requiring transfer from SBUHB to another hospital for specialist surgical or paediatric subspecialty support allowed the review team to understand the interface between the neonatal MDT and other paediatric services.

5.81 The review team saw evidence of geographical isolation when babies required surgical/subspecialty input:

- Surgical support, particularly in babies with NEC, was inconsistent.
- Referrals were generally made in an appropriate timeframe. Cot capacity at the University Hospital Wales (UHW) in Cardiff appeared to influence the decision to transfer in a small number of instances.

Service provision

5.82 As noted above there has been a lack of full-time paediatric radiology provision within the Health Board for some time. Formal radiology reporting is undertaken on a ‘less-than-full-time’ basis leading to ‘batch’ reporting of plain films several days after images have been taken. The quality of plain radiographs is variable. There was little evidence of review of the clinical interpretation of X-rays when formal reports became available.

5.83 Cranial ultrasounds are performed frequently on sick babies by a large number of the clinical team. The images are recorded on heat-sensitive paper and affixed in the case notes. This

limits opportunities for quality assessment and improvement. Cranial ultrasounds are not formally reported by a paediatric radiologist.

5.84 There is a lack of embedded Allied Health Professionals within the neonatal service, including Pharmacy, Physiotherapy, Speech and Language Therapy, Psychology and Dietetics.

Review of maternal admissions to ITU

5.85 Maternity services are located at Singleton Hospital and Neath Port Talbot Hospital Birth Centre. The Singleton Hospital Labour Ward /delivery rooms, obstetric theatre, and High Dependency Unit (HDU) provide 24/7 midwifery/obstetric and anaesthetic cover. The Intensive Therapy Unit (ITU) is based at the Morriston Hospital site which is approximately 40 -60 minutes ambulance journey transfer time from Singleton Hospital. Admissions of mothers from Singleton Hospital maternity unit to ITU are rare.

5.86 We reviewed cases in which women had been admitted to the ITU during their maternity pathway (antenatal, labour, postnatal). Each case was reviewed independently by an intensivist/anaesthetist, an obstetrician and a midwife. Cases were reviewed using the clinical notes, Datix forms, serious incident reports, patient complaints and any other investigations done by the Health Board.

5.87 The review team then jointly discussed each case and assessed the care provided as either optimal, adequate, poor, or insufficient information. The team compared findings with any internal Health Board investigations and finally drew conclusions and identified themes. A standard template was completed for each case to record the findings. In the quality assurance sessions, we confirmed whether there were modifiable factors, and whether these were major or minor. We also reviewed the two self-referral cases for ITU review using the same method. We reviewed a total of 22 cases.

Modifiable factors for the ITU cohort

The table below sets out the modifiable factors identified in this cohort of 22 women. There were 20 major MFs identified.

Table 14: ITU modifiable factors (cohort 22 women)

Modifiable factor (MF)	Wider learning	Minor	Major
Pre-pregnancy or preconception care	0	0	0
Assessment or point of entry to care	1	1	2
Diagnosis or in the recognition of high-risk status	1	0	4
Referral to a specialist	0	0	1
Treatment	3	3	8
Clinical leadership	2	2	1
Education, knowledge, and training	3	2	2
Documentation	2	2	0
Discharge or transfer from care	11	0	1
Communication	7	0	1
Policy and procedures	18	2	0
Woman and her family	0	1	0
Total (no. of MFs)	**48**	**13**	**20**

Key Themes:

There were some key themes that emerged across multiple cases. These related to:

- Recognition of deterioration, escalation, and use of MEWS.
- Provision of enhanced maternal care at Singleton Hospital.
- Provision of outreach and maternity-specific critical care at Morriston Hospital.
- Incident reviews and complaint responses.

Maternal Early Warning Scores (MEWS)

5.88 MEWS should be used to monitor the physiology of pregnant women and identify signs of clinical deterioration. A maternity specific early warning score is in use within the Singleton maternity unit but NEWS2 is used in other areas of the hospital including ITU, A&E and non-maternity ward areas. NEWS2 is not designed to pick up deterioration in pregnant women; for example, the blood pressure thresholds will not identify hypertension that requires escalation for treatment.

Recognition of deterioration and escalation

5.89 We identified several instances where there were delays in identifying and escalating deterioration. Maternity specific early warning score charts were being used in these cases, but escalation processes were not always followed. In several of these cases women were septic and delays in escalation led to delays in administration of antibiotics and other aspects of sepsis care.

Provision of enhanced maternal care at Singleton Hospital

5.90 The geographical challenge of having critical care and maternity services on separate sites was highlighted in several cases reviewed; we identified aspects of care that could be improved to help mitigate this.

5.91 Hospitals differ in their configuration of care for women who are critically ill during pregnancy, birth, or the postpartum period. The underlying principle of caring for any sick pregnant or recently pregnant woman is that they are looked after by someone with the appropriate competencies, in the appropriate place in that hospital. Enhanced maternal care (EMC) is the term that has replaced what used to be called high dependency care in maternity. It encompasses all care from the point at which the team are concerned that the woman is at high risk/has started to deteriorate up until the point of transfer to critical care.

5.92 There is no ‘one size fits all’ model to provide critical care in maternity units. Expecting Singleton maternity unit, which has relatively few sick women, to train midwives to use invasive monitoring is unlikely to be successful; while training staff may be possible, maintaining competence is more challenging with a small throughput of women requiring this monitoring.

5.93 Many units throughout the UK provide excellent collaborative enhanced maternal care in ways suited to their particular unit. Larger units with a higher throughput of women who require critical care can provide enhanced maternal care in the labour ward, with midwives trained in a broad range of enhanced care competencies, including care involving routine use of invasive monitoring.

5.94 For maternity units of the size of Singleton, it is still possible to introduce enhanced maternal care, albeit with a slightly lower threshold for transfer to critical care. In units that have done this successfully, they have recognised that the number of women requiring invasive monitoring is insufficient for midwives to maintain the necessary competencies. Enhanced

care midwives with the skills required for that unit are still available every shift to look after sick women, but anyone requiring invasive monitoring is transferred to critical care.

5.95 Given that the ITU unit is in a separate location at Morriston Hospital, a third model, used by some units, may be more suitable. This third model involves integrating critical care nurses into the maternity team. Midwives and critical care nurses work together to care for women requiring enhanced care, collectively having all the midwifery and critical care competencies required.

Provision of outreach and maternity specific critical care at Morriston Hospital

5.96 General critical care provision across the cases reviewed was of a good standard. However, maternity specific aspects of care were less well managed. Some of this related to the geographical challenge of having critical care and maternity services on separate sites but we identified aspects of care that could be improved to help mitigate this.

5.97 Admission of a pregnant or recently pregnant woman to critical care is infrequent. The National Maternity and Perinatal Audit Maternity Admissions study into intensive care in England, Wales and Scotland identified a rate of 2.75/1000 women in pregnancy, birth and up to 1 year after delivery who required admission to an adult ITU. As such, the service needs to consider how best to support staff to manage these cases, including in person daily review by the maternity team to support ITU colleagues in the maternity specific aspects of care.

5.98 ITUs admitting critically ill maternity patients need to be prepared for severe maternal morbidity and potential adverse events with relevant protocols, equipment, drugs, and trained staff promptly accessible. Use of aide-memoires, admission checklists and simulation of rare maternity events such as emergent delivery on the ITU, or management of postpartum haemorrhage, can help teams to feel more familiar with maternity presentations, and also test the environment with respect to kit and logistics. Maternal critical care competencies for critical care and outreach nurses have also recently been published, to guide learning for staff.

5.99 Critical care outreach can provide vital support to the maternity unit in the management of women requiring enhanced maternal care and help with the multidisciplinary decision making to transfer to critical care. Where there is unavoidable delay in transfer to critical care, outreach can also help the maternity team to care for the woman, ensuring that women receive the care they require, regardless of their location in the hospital.

5.100 In some instances, the on-call intensive care consultant attended the maternity unit at Singleton Hospital to advise the team and assess the need for transfer to ITU, but this did not happen in all cases.

Incident reviews and complaint responses

5.101 We noted that there was an inconsistent approach to reporting incidents, and in the classification of the severity of the incidents. A Datix report was not completed for every case when a woman was admitted to ITU (unplanned and unexpected admission); some cases had internal reviews and others serious incident investigations.

5.102 In many cases the Datix report was classified as ‘no harm’ despite the woman being admitted to ITU, or having had a major clinical complication, including life-altering complications such as hysterectomy. This classification is incorrect and does not reflect a patient-centred approach.

5.103 The case investigations and reviews did not include an external person as part of the multidisciplinary panel which limits their impartiality – ‘marking your own homework’. The reviews were often superficial, self-praising and the learning limited. Reports generated by

the reviews were not written with women and their families in mind and this was reflected in the complaint responses which did not address patients' and families' questions.

5.104 When undertaking a review of an incident, it is important that reviewers remain curious, challenging and working collectively within the multidisciplinary team. Time needs to be allocated for health professionals to undertake the reviews in a timely manner. It is important that reports from the reviews, which will be available to a family, should be written in a user-friendly manner explaining the issues that could have impacted on the outcome. It is important that the reviews look at recommendations rather than attributing blame.

5.105 The complaint responses were not timely, and included defensive language, patient blaming and apparent use of 'cut and paste' stock phrases.

5.106 The findings from incident and complaint management are considered further in section 7.

Additional Themes

5.107 In addition to the above main themes, we noted:

- Variable involvement of other specialities antenatally, and limited access to medical reviews.
- Provision of postnatal obstetric debrief was inconsistent, particularly if other specialities were involved in the woman's care.
- Poor quality of consent form content and completion (which is a legal obligation).
- Use of language lines instead of in-person interpreters.
- Good support of consultant colleagues from other consultants during big emergencies.

Review of maternal deaths

5.108 Our review also included a small number of maternal deaths. The scope of this element of the review was limited to reviewing the Health Board internal serious incident reports. The aim was to seek assurance on the quality of reviews and the learning that the Health Board has taken forward following review. We did not have access to the original patient records. Only limited assurance could be found in respect of the review of the care undertaken. As with the ITU cases, the Health Board needs to significantly improve the review processes and to include an independent member.

Conclusions and specific recommendations

5.109 The clinical review has identified a considerable number of modifiable factors which have resulted in additional learning for the perinatal service and the Health Board. The recommendations below will have a significant impact on the quality of service delivered. The majority of these are relatively straightforward to address and require little in the way of additional resource.

5.110 The specific recommendations below have been included for clinical teams and should be implemented as soon as possible and included in a programme of rolling audit.

Maternity recommendations

1) The antenatal telephone triage process should be reviewed to follow good practice guidance. This should include ensuring the triage service has the right levels of staffing and staff with the appropriate skill mix.
2) Management of the latent phase of labour should be reviewed in conjunction with the antenatal triage process to ensure timely admission and assessment.

3) The induction of labour (IOL) pathway should be reviewed to ensure there are minimal excessive delays in the IOL process. There should also be evidence of an appropriate written risk assessment when delay occurs.

4) There should be a robust process in place for the timely MDT review of clinical guidelines and a process for the cascade throughout the service.

5) There must be single guidance for all staff dealing with women who experience decreased fetal movements. Such guidance should adhere to previously published guidance by NICE and the RCOG.

6) Categorisation of CTGs should always be undertaken and documented.

7) Caesarean sections should be appropriately categorised according to clinical picture.

8) Caesarean sections should be undertaken in the specified timeframe using recognised parameters.

9) Complex operative vaginal deliveries such as rotational forceps and assisted breech deliveries must be conducted by appropriately trained clinicians under the direct supervision of a consultant.

10) Complex caesarean sections such as in patients with multiple previous caesarean sections or in severely obese patients must be conducted by appropriately trained clinicians under direct supervision by a consultant.

11) When there is a clinically suspected case of a morbidly adherent placenta there should be a multidisciplinary team discussion regarding the optimal timing and place of delivery.

12) There should be the appropriate resource of specialist bereavement midwives to cover annual leave/training.

13) Training should be provided to a core of staff to ensure that good bereavement care is accessible overnight and at weekends.

14) Standards for documentation accuracy and completeness should be developed.

15) A partogram should always be completed when caring for women experiencing stillbirth.

16) Prescribing standards should be in line with guidance applicable across the UK.

17) The obstetric/midwifery team should ensure appropriate implementation of a sepsis pathway in keeping with applicable guidance.

18) The processes for follow up/debrief of families after discharge to provide a coordinated approach across the maternity/neonatal system should be reviewed.

19) The obstetric/midwifery team should ensure that the appropriate level of neonatal support is requested at delivery within an appropriate time frame.

20) Safeguarding plans should be shared throughout the maternity and neonatal service to ensure a seamless service.

21) All complex maternal or fetal pregnancies should be discussed in a multidisciplinary forum with the tertiary unit at Cardiff and Vale University Health Board (CAVUHB) in order to plan the optimal timing and place of delivery.

22) Serious incident reviews must be carried out using the guidance in place across England in the Patient Safety Incident Response Framework (PSIRF).

23) A maternity specific early warning score should be used for all pregnant and recently pregnant women rather than NEWS2, wherever they are cared for in the hospital.

24) Training in the recognition and escalation of deterioration should be implemented for all midwifery staff caring for women at risk of deterioration. There are a variety of courses available in the UK that address the competencies required, for example the training provided by the Association for Improvements in the Maternity Services (AIMS).

25) Pregnant or recently pregnant women should have access at all times to a healthcare professional who has enhanced maternal care competencies. If the maternity unit policy is to care for patients with an arterial line in the maternity unit rather than transferring to critical care, then staff caring for the patient should be competent in the use and care of arterial lines, rather than relying on intermittent input from the anaesthetic team.

26) All maternity patients admitted to intensive care must have evidence of a clearly documented multidisciplinary consultant-led review at least once every twenty-four hours. The team attending the patient must include an intensive care consultant and an obstetric consultant and will ideally also include an anaesthetic obstetric consultant and a senior midwife. This should be included in the role and responsibilities of the on-call obstetric team.

27) When admitting maternity patients, ITU must be prepared for obstetric emergencies such as postpartum haemorrhage, including a plan for urgent in person obstetric review when needed.

28) The current staffing model should be reviewed, including outreach nursing/ ITU medical cover when required at Singleton Hospital. The midwifery/obstetric staffing model to care for maternity patients admitted to Morriston ITU should be considered and obstetric consultant job plans should be reviewed to enable obstetric reviews whilst on ITU.

29) Local measures must be in place to promote and facilitate breastfeeding, including milk expression, and to ensure routine contact between a woman and their newborn whilst receiving intensive care.

30) Any unexpected admission of a maternity patient to critical care requires a review of the care provided and depending on the clinical circumstances a serious incident review.

31) Incident reviews should include an external person to complete the multidisciplinary panel, and the review panels should be appropriately resourced to be able to complete reviews in a timely manner.

32) Complaint responses should be timely and prepared thoughtfully, mindful of the complainant and focused on learning and improving care.

Neonatal recommendations

33) The process for requesting timely neonatal staff attendance at births (including consultant staff) should be reviewed.

34) Obstetric, midwifery and neonatal staff should ensure consistency in recording details of perinatal events.

35) Details of the clinical care required and the condition of infants immediately prior to and during transfer from the delivery suite to NNU should be fully documented.

36) All infants should have a full, documented examination on admission to NNU.

37) Antibiotic treatment should be commenced within 1 hour of the decision to treat.

38) Consideration should be given to the use of heat sources (e.g. Transwarmer®) during procedures to prevent hypothermia.

39) Clinical education/simulation on NNU should include a focus on wider causes of an infant's deterioration.

40) Practices around antibiotic decision making should be reviewed and rationalised to ensure alignment with relevant guidance. Quality improvement work, pre-2018, should be reviewed to ensure the risk of sepsis in all neonates in the neonatal service remains high on the list of differential diagnosis.

41) Frequency of blood gas analysis particularly following identification of hypocarbia should be reviewed and rationalised.

42) Rationalisation of in-dwelling devices should be undertaken regularly. There may be benefit from a review of current guidance (e.g. the current fluid guideline states, “avoid catheterisation”).

43) The NNU’s guideline associated with fluid management is long and complex and would benefit from review to streamline and make clear statements regarding an approach to fluid management in line with the current evidence-base.

44) Review guidance around blood sugar management to make clearer pathways for decision making.

45) Neonatal and radiology staff should review practice to improve the quality of plain X-ray images in critically unwell infants.

46) The Health Board should seek to provide full time paediatric radiology cover as a matter of urgency.

47) Standards for documentation accuracy and completeness should be developed to cover the entire neonatal ‘journey’ from delivery to discharge.

48) Nursing narrative documentation should be complementary to the medical notes.

49) Prescribing standards should be in line with relevant UK guidance.

50) Senior staff oversight of Badgernet discharge summaries should be considered to ensure that these are accurate and convey appropriate narrative details for families.

51) The process around formal discharge summaries and subsequent contact with bereaved families should be reviewed. The timeline for this process should not be influenced by availability of the results of postmortem examination and investigation. We suggest that discharge summaries should be completed within two working days of an infant’s death and the first written contact with families for follow-up be sent six weeks following the death, offering an appointment approximately six weeks later.

52) Mortality reviews should be undertaken as a multidisciplinary team, using a standardised tool such as the PMRT.

53) Outputs from mortality reviews should capture all learning identified. There should be a clear process to disseminate this learning to the perinatal MDT.

54) The process for investigating, reporting and disseminating learning from clinical incidents should be reviewed.

55) Current neonatal unit cot occupancy and medical and nursing staffing levels should be reviewed against current UK recommendations to ensure a safe and sustainable service.

56) A review of the interface between the neonatal team and other paediatric specialities, including paediatric surgery, should be considered.

5.111 Additional clinical recommendations

57) Review the current staffing model, including outreach nursing/medical cover when required at Singleton Hospital as well as enhanced maternal care, either by midwives

with additional competencies and /or critical care nurses as per the Intensive Care Society's ICS) Enhanced Maternal Care guideline.[62] Consider the midwifery/obstetric staffing model to care for maternity patients admitted to ITU at Morriston Hospital in line with the Faculty of Intensive Care Management/ICS Guidelines for the Provision of Intensive Care Services.[63]

58) Escalation to anaesthetic and obstetric consultants should happen promptly when a woman is critically unwell.

59) Prompt delivery should be considered in cases of severe uterine sepsis / disseminated intravascular coagulation (DIC) /HELLP syndrome.

60) Processes should be in place to facilitate early recognition with prompt (within 1 hour) administration of antibiotics in cases of suspected sepsis.

61) The Obstetric Bleeding Strategy (OBS) Cymru[64] protocol should be followed in all haemorrhage cases to aid rapid correction of coagulopathy.

62) CTG should not be used to monitor uterine contractions when stillbirth has been confirmed.

63) Any unexpected admission of maternity patients to critical care requires a post event review of the care provided.

64) Electronic prescribing should be initiated in the Health Board to improve legibility and documentation of timings of drug administration.

65) Education and learning about fluid management should be embedded within the whole clinical team, to ensure that all staff are aware of the need to maintain a fluid balance chart and to be aware of the risk that fluid overload presents to electrolyte balance, and the risk of maternal and neonatal seizures.

66) Prioritise the patient and baby being together; if this is not possible, the patient and family should be provided with regular updates. Local measures must be in place to ensure routine contact between the woman and the newborn whilst receiving intensive care.

67) Processes should be in place to recognise and treat deteriorating patients (e.g. postpartum haemorrhage, sepsis), escalate to senior staff promptly and return to theatre when necessary.

68) An assessment should be made at the end of a theatre case to decide whether a patient is well enough to be extubated and be cared for in the maternity unit. Where this is not the case, the patient should be transferred directly to critical care.

69) Obstetric debriefs should be offered to all women admitted to ITU in their pregnancy pathway even when the main cause of the ITU admission was non-obstetric.

6

6. Staffing, leadership, and culture

Summary

What are the key issues?

Between 2021 and 2024 there were: low and inconsistent staffing levels (predominantly in midwifery staff); weaknesses in leadership, leading to lack of oversight of staff rosters, limited escalation of staff concerns, and low insight into those concerns; and low compliance with mandatory training.

There are both historic and current concerns with: the maternity triage system, inconsistent and absent supportive advice and information given to women calling the service, lack of senior medical presence in triage, and lack of monitoring of the quality of the service.

What is currently in place?

Since 2024 there has been a significant increase in staffing levels, although this has led to a shift towards more newly qualified and less experienced midwives, and neonatal nurses. There are now improved staffing levels in the medical neonatal workforce.

There have been changes in leadership, which include: the establishment of a Clinical Director of Midwifery role and a new Clinical Director of Obstetrics and Gynaecology, as well as enhanced midwifery capacity for governance. The role of the governance midwife requires urgent review to ensure there are multidisciplinary panels for investigations and to avoid reliance on one specific role.

There has been investment in training, and there have been significant improvements in compliance with mandatory training. There has also been investment in community midwife training, and weekly professional training updates for midwives. PROMPT training has been introduced, but this requires greater attendance from obstetricians.

There is a high rate of reporting of clinical incidents (showing a positive learning culture) but staff report a lack of feedback following reporting.

There is increasingly positive feedback from student midwives and medical trainees, but still some examples of incivility amongst teams.

The Birmingham Symptom-specific Obstetric Triage System (BSOTS) has been introduced.

What is being progressed?

Improvements to staffing in triage, monitoring of staffing levels, and waiting times for assessment.

Evaluation of the BSOTS system

Increasing the attendance of obstetricians for Practical Obstetric Multi-Professional Training (PROMPT) training

What more is there to be done?

Urgent action is required to improve the quality of triage and service access. This must include: a move to a single process for maternity triage; additional experienced midwifery staffing; improvements in the environment, with a confidential space to take calls; assessment of all women within 15 minutes; improving the quality of calls and women's experiences when contacting the service; and increased senior medical input available for all women.

Close monitoring of the triage service's activity, performance and patient experience.

A development programme should be provided to support newly qualified midwives.

A development programme should be provided for all staff which includes: team working; compassionate care delivery; a just and learning culture; and trauma-informed practice.

What are the immediate priorities?

- Urgent progress of action re triage (see above).
- Review of the governance midwife role (see above).
- Further development of key leadership roles across midwifery and obstetrics.
- Improvement in access to and quality of debriefs, ensuring staff recognise all have a responsibility for debriefing and compassionate response to harm.

Staffing levels and skill mix

Overview

6.1 Like other parts of the UK, the NHS in Wales has been significantly impacted by staff shortages over recent years. Data published by the Welsh Government in 2023 revealed 4,966 full-time equivalent (FTE) vacancies across the Welsh NHS. Notably, 2,409 of these vacancies were for midwives, registered nurses, and health visitors - underscoring the acute pressures facing the midwifery profession and wider nursing workforce[65].

6.2 High levels of staff turnover in midwifery are a significant problem in the NHS, one that has worsened since the Covid-19 pandemic. According to data published by the Royal College of Midwives in 2021, over half of midwives were considering leaving their roles, with 57% planning to leave the NHS within the next 12 months. In obstetrics, 80% of UK trainees reported seriously considering leaving the profession, primarily due to the emotional burden of the specialty. Among midwives who had already left or were contemplating leaving, more than eight in ten cited concerns about staffing levels, while two-thirds expressed dissatisfaction with the quality of care they were able to provide [66].

6.3 The HIW National Review of Maternity Services[67] published in November 2020, highlighted the significant stress caused by unfilled vacancies and unplanned absences within the maternity workforce. The report found “staff from all disciplines working in excess of their contracted hours, frequent last-minute cancellation of training sessions, and reductions in reported staff wellbeing and morale.”

6.4 Turnover among newly qualified midwives is a particular problem in Wales and England. The highest levels of dissatisfaction among those surveyed were reported by midwives with five years or less experience working in the NHS. The Nuffield Trust reports that around 10% of midwives across the UK leave NHS hospital and community settings within two years of completing their training. However, that is a rate significantly lower than that of other health professionals such as nurses, radiographers, and physiotherapists, where the figure is closer to one in five[68].

6.5 High turnover of staff, staff morale and the experience of staff form a circular issue. Midwives who are recently trained and new to the workforce need extensive mentoring and support to build them into confident professionals and future leaders. However, many are unable to provide care in line with the standards and values emphasised during their training, leading to disillusionment, stress and burnout. As a result, these midwives often leave the profession, placing additional strain on remaining staff and contributing to a less safe, less person-centred environment for women during childbirth.

6.6 Neonatal services also face similar, long-standing challenges associated with recruitment and retention. In the years prior to the pandemic, alarm bells were already raised about:

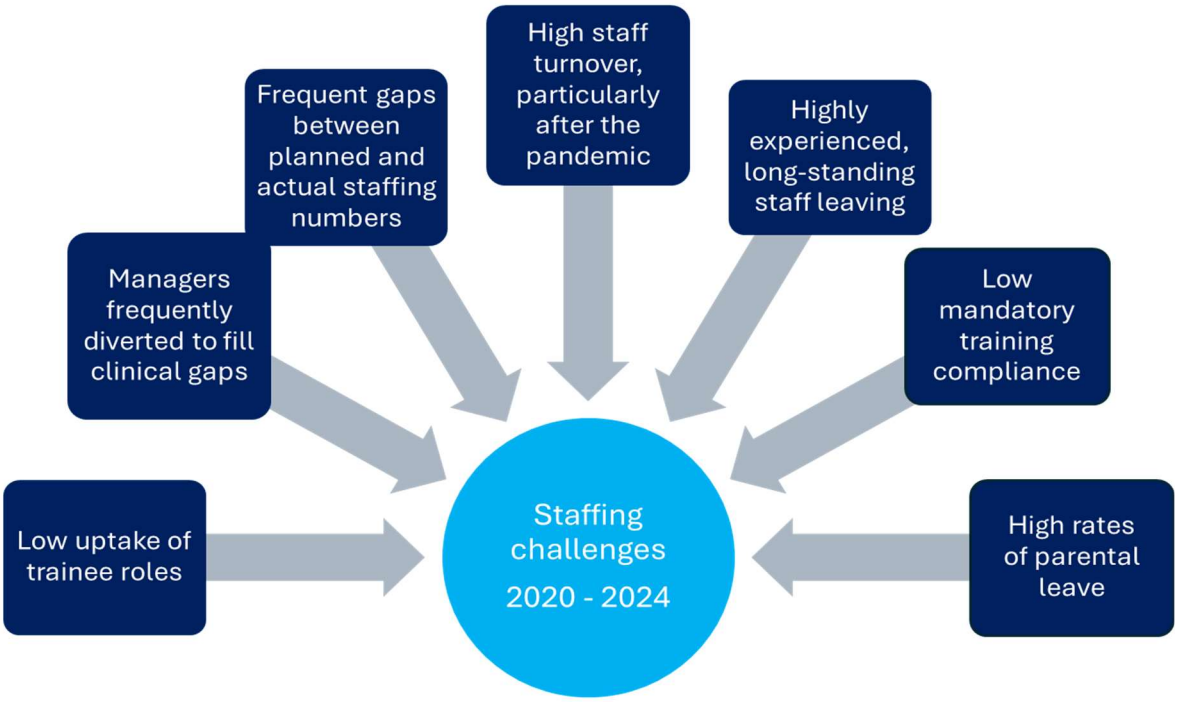
- the number of neonatal units which had fewer nurses in post than recommended by BAPM standards[69];
- a steady reduction in the number of nurses who had achieved 'qualified in specialty' (QIS) status post-registration[70] ;and
- high numbers of highly experienced nurses expected to retire[71], an expectation that was largely accelerated by the pandemic.

Staffing levels

6.7 Between 2020 and spring 2024, staffing levels in both services had been inconsistent. Whilst there had been periodic efforts to improve staffing numbers during this time, we found strong evidence that there were consistent concerns about gaps in rotas, failure to recruit to establishment and the resilience of the existing workforce in both services.

6.8 The diagram below illustrates some of the key, persistent stress indicators on safe staffing, from 2020 onwards:

Staffing challenges 2020 – 2024



6.9 The Covid-19 pandemic marked a critical inflection point in the midwifery staffing crisis. Between 2020 and spring 2024, maternity services, and to a lesser extent neonatal services, faced sustained and severe staffing shortages. In our interviews, we consistently heard references to long-serving, highly experienced staff who chose to retire in the aftermath of the pandemic. While some retirements had been planned previously, many had been brought forward due to the pressures experienced during the pandemic period.

6.10 Staff told us that, in the years following the intensity of the initial waves of Covid-19 in 2020-2021, shift fill rates were consistently below required levels. The Board was told in December 2022 that maternity staff were fatigued, having been under significant pressure stemming from "staffing shortages in a service that didn't see any reduction in demand."

6.11 To attribute staffing fragility solely to the pandemic would overlook several long-standing, systemic issues both within the Health Board and in wider national workforce planning. Our review of key meetings dating back to 2020, alongside discussions with staff and wider stakeholders, indicates that the pandemic served to expose and intensify the impact of these pre-existing challenges, including:

- **Leadership capacity and capability** – in summary, there was a perception of disconnected leadership in maternity resulting in staff feeling unsupported. This was compounded by the loss of key lead and specialist roles, such as the intrapartum lead and labour ward coordinators in 2022, which weakened the connection between key staff groups, such as those on labour ward, with service leadership. This is explored more thoroughly later in this section.
- **Escalation** – the process of escalation lacked definition and clarity. Staff described a reactive and sometimes chaotic response to periods of intense acuity, exacerbated by unclear mechanisms to measure and report staff availability.
- **Oversight of staffing** – we found the data reported on maternity staffing (such as vacancies, sickness, turnover) to be disparate and hard to identify in reporting within the service and out to the directorate and beyond. This is explored in section 7 from a governance perspective, but it was clear from many staff we spoke to that there was a lack of operational understanding about the staffing position. We were told "until recently, there wasn't a consistent understanding of what the vacancy rate was between members of the senior team."
- **Roster management** – staff told us that this was ineffective and often reactive. We heard that the weaknesses in leadership capacity meant that the development and approval of rosters lack rigour. The result of this, we were told, was a service that had normalised the moving of staff at short notice to support understaffed areas.
- **Recruitment** – the pipeline of newly qualified midwives and nurses was, until late 2024, limited. This resulted in the Health Board being unable to directly address the staffing shortages. For example, in 2022, maternity was able to fill only 50% of its Band 5 graduate midwife posts.
- **Insight into what concerns staff** – Staff had limited day-to-day opportunities to voice their concerns about staffing shortages and the ongoing impact of working under sustained pressure. This was exacerbated by the high number of interim management positions, which left staff unclear about whom to approach and made it more difficult for them to speak candidly about their concerns. Several staff shared the perception that the Health Board had normalised relying on the discretionary effort of substantive staff to do more.

6.12 The impact on maternity service provision and choice for women and families has been pronounced. In 2021, the high rates of registered staff unavailability, which peaked at 37% in July 2021, resulted in the closure of the freestanding midwifery unit (FMU) at Neath Port Talbot in September 2021, and the centralisation of maternity services. Further concerns were highlighted during the HIW inspection in September 2023, which found that midwifery staffing levels were below the establishment required on 11 out of the 14 days preceding the visit.

6.13 Sickness absence rates have been a significant concern in maternity. Rates for Maternity Healthcare Assistants, Maternity Care Assistants and Nursery Nurses peaked at just over 20% in early 2024, with midwifery sickness absence hitting almost 12%. Several actions have been taken to combat high sickness rates in maternity, oversight of which has been reported to the Health Board's Workforce and Organisational Development Committee. These have

included: sickness audits; Managing Attendance at Work (MAAW) training; close review of long-term sickness cases in conjunction with corporate human resources colleagues; and a deep-dive exercise to review at least 50% of staff files against the MAAW policy.

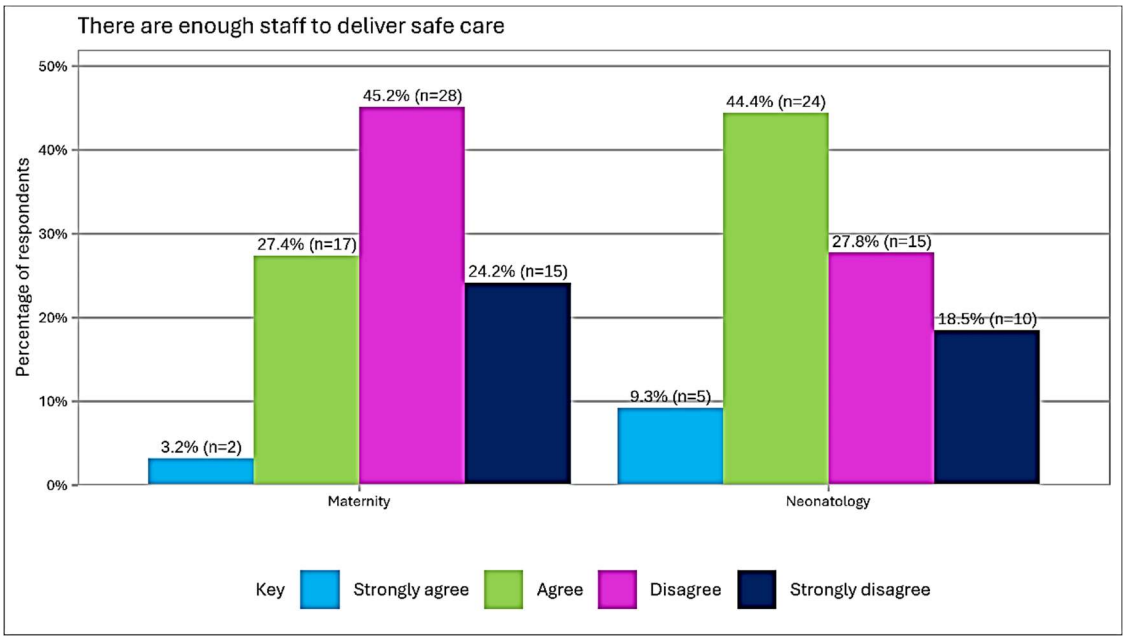
6.14 A listening and observational review of the midwifery workforce was undertaken in March 2023 which set out to the Health Board: "the workforce pressures as a result of high unavailability of staff due to recruitment and retention challenges, higher than average maternity leave and sickness absence…compounded by increased workload and acuity linked to the suspension of community intrapartum pathways." The result was several recommendations, managed via a Maternity Workforce Transformation Action Plan. Foremost among these was the call for a £750,000 investment to align the midwifery workforce with BirthRate+ staffing requirements. The urgency of this investment and the need for a revised and targeted review of workforce planning, was reinforced by HIW findings published six months later.

6.15 In 2024 and early 2025, the Health Board has made significant inroads to break the cycle of low staffing numbers, reduced staff experience and poor staff morale. Investment agreed in late 2023 followed shortly by recruitment commencing for midwives and maternity support assistants, has enabled the service to meet planned midwifery staffing for both day and night shifts. By April 2024, the maternity service was able to report that it was fully established.

6.16 Early indicators suggest that the workforce, previously under considerable strain, is now showing signs of improved stability and resilience. In particular:

- maternity has not employed agency staff since December 2024;
- 21 qualified midwives have joined, as well as 15 maternity support workers; and
- sickness absence rates have fallen significantly.

6.17 Despite encouraging signs of improvement, maternity staff are still under significant strain. As illustrated in the graph below from 2024, anxiety about safe staffing levels in maternity remains high, suggesting that improvements in resourcing have not yet translated into a sense of confidence or security among staff.



6.18 Community staff also voiced concerns about unsafe staffing levels. Several described caseloads as exceeding safe practice and expressed a view that the Health Board lacks a sufficiently evidence-based understanding of community capacity and demand. A representative comment in this area was, “staffing in the community is spread very thinly.” They also expressed their frustration “that senior managers don’t have insight into being a community midwife.” That said, views were not uniform. Others told us that “community staffing has never been as good as it is today.”

6.19 The Welsh Government currently mandates the use of BirthRate+ to understand capacity and demand and inform service design. An assessment has not been undertaken since 2023, when it reported a variance of 5.24 WTE below funded clinical establishment. We understand that the service intends to undertake a BirthRate+ assessment at some point this year. It was evident that there are mixed views about the effectiveness of BirthRate+ with some staff voicing their scepticism that it will give an accurate picture of the demands placed on staff based on activity, case mix, demographics and skill mix.

6.20 The neonatal service uses the British Association of Perinatal Medicine (BAPM) framework to plan and monitor staffing levels against acuity. Neonatal nurse staffing is also a performance measure under the Royal College of Paediatrics and Child Health (RCPCH) National Neonatal Audit Programme (NNAP). BAPM focuses on patient acuity, whereas NNAP reviews nursing numbers against cot capacity.

6.21 Most neonatal staff who responded to the survey agreed to some extent that there are enough staff to deliver safe care. Like maternity, there was significant investment in recruitment during 2024; this included:

- the recruitment of 22 WTE international nurses;
- over-recruiting to Band 5 posts and reviewing the structure of the qualified in specialty (QIS) training on order to shorten the time it takes for experienced Band 5 neonatal nurses to be in a position to apply for Band 6 posts. This partially mitigates the impact of shortages in Band 6 neonatal nurses. For example, in April 2025 there were 9.7 WTE Band 6 vacancies, but 9.32 WTE Band 5 nurses above establishment;
- expanding the practice development nursing capacity; and
- investing in training more Advanced Neonatal Nurse Practitioners (ANNPs) to strengthen the capacity of the neonatal medical workforce.

6.22 The service has not been consistently compliant with British Association of Perinatal Medicine (BAPM) standards due to consultant capacity to achieve the 12-hours a day, 7-day per week standard at the weekend. The appointment of two locum consultants in Spring 2025 should address this.

6.23 At the time of reporting the service is also currently without a substantive service manager.

6.24 A key source of workforce pressure in the neonatal department is the Cymru inter-Hospital Acute Neonatal Transfer Service (CHANTS). The service covers South Wales and is delivered by staff from each of the three NICUs in South Wales, which are Swansea, Newport (ABU Health Board) and Cardiff (CAVU Health Board). Each team covers the service 1:3 weeks in rotation. Each day there is a dedicated Neonatal Consultant, a Transport Nurse and an ambulance driver in a dedicated CHANTS ambulance. It operates 24-hours a day, 365 days per year, but the service provision differs between day and night:

- Between 8am and 8pm, CHANTS is a fully operational on-site consultant delivered service, with the ability to provide uplift, repatriation and capacity transfers.

- Between 8pm and 8am, CHANTS will have a specific focus on transferring any baby identified as needing an uplift to a higher level of care, using identified criteria and operated by an on-call consultant model.
- CHANTS is currently commissioned on an interim contract. The resultant risk is that the operating model for the service is not underpinned by a mutually agreed staffing and remuneration package and therefore is currently reliant on the goodwill of the consultant body, several of whom we understand have raised concerns about the sustainability of this approach.

6.25 Through our work, we became aware of a number of aspects of both services that staff reported to be under-resourced. These are summarised in the table in appendix 5.

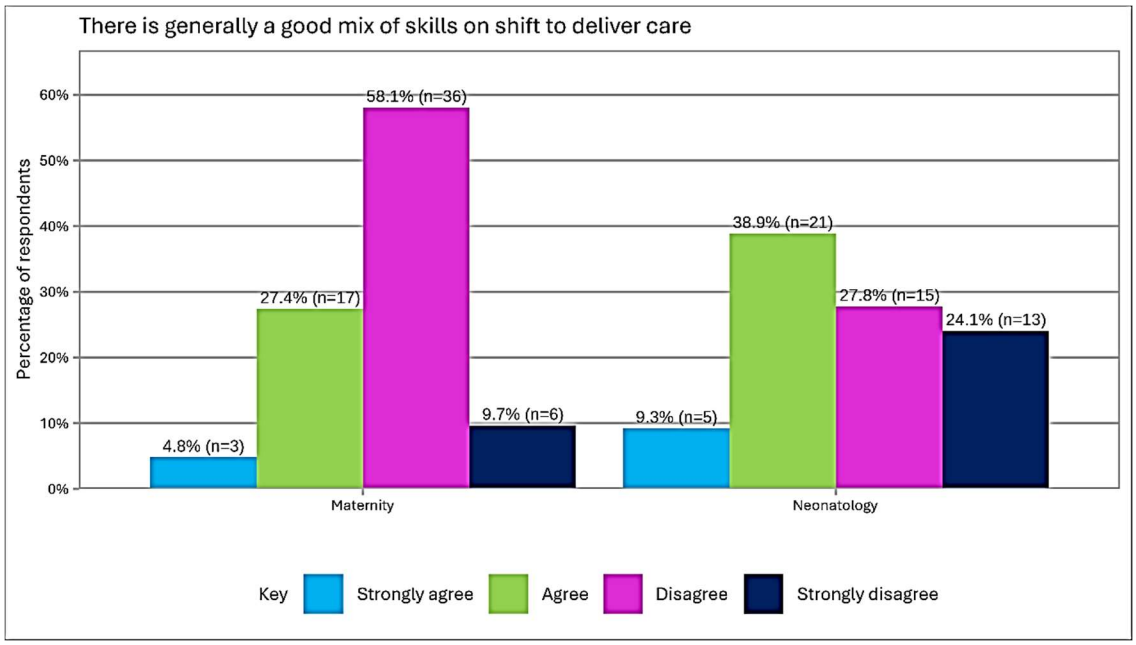
6.26 We understand that most of the areas listed in the table will be addressed via the Strategic Perinatal Workforce Plan for Wales[72] and are also embedded within the Health Board's response to the All Wales Maternity and Neonatal Safety Support Programme (see section 7 for more detail). HEIW announced its approval of the plan in April 2025 and stated that it would be launched in Spring/Summer 2025.

6.27 A Staff Experience, Wellbeing and Retention Plan is also under development in recognition of both the pressure staff have been under and the need to proactively support staff to want to stay and build their careers at the Health Board. This work commenced in November 2024 with 'Café Conversations', an informal drop-in opportunity for staff to meet service leaders to share their views on what would improve staff experience and retention.

6.28 We note that the service does not have a Retention Midwife; without resolution, this could be a key limiting factor to the success of the Staff Experience, Wellbeing and Retention Plan.

6.29 Given the findings above, and the continued pressure staff will feel as the result of this review, we were surprised that the wellbeing of staff is not on the service-level risk register. Safe, responsive and compassionate care is only possible if staff can function to the best of their abilities. We suggest that whilst there are positive signs that staff morale is improving, the risks associated with a workforce under continued strain should have higher prominence in the Health Board's approach to risk management. This is explored further in section 7.

6.30 Skill mix was the most reported concern amongst staff we spoke to from both services, and this was echoed in the survey results:

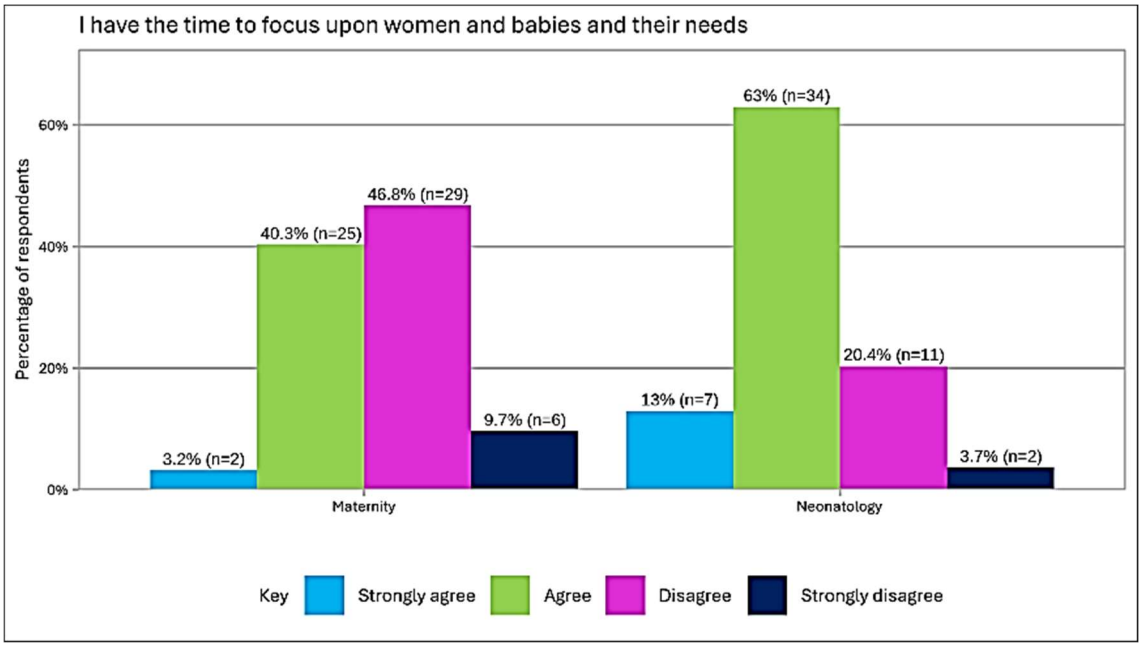


6.31 Virtually all staff we engaged with said they feel workload pressures due to an imbalanced skill mix. The influx of new staff in 2024 has changed the profile of skills in both services. We were told that the pressure to provide high-quality care in services that depend on deep knowledge and experience to identify escalating clinical risks early is significant, whether caring for a woman during spontaneous vaginal birth or a premature baby in NICU. The pressures of increasing planned caesarean section and induction rates further amplify the pressures associated with skill mix.

6.32 We heard accounts of staff feeling heightened anxiety on certain shifts where there was a high number of newly qualified staff. More experienced staff described the intense pressure they sometimes feel to support less experienced colleagues, while maintaining high standards of quality and safety for those in their care. This is compounded by the lack of proportionate increase in professional development capacity in either service. Further examples of staff concerns shared with us about skill mix include:

- "The service is currently very bottom heavy with lots of inexperienced midwives." (maternity service)
- "Overall numbers are much better, but we are a junior workforce." (maternity service)
- "There are lots of inexperienced staff who need guidance and support." (neonatal service)
- "Some shifts feel like you have to be all over everything, even if it isn't your job." (neonatal service)
- "There are lots of junior staff on the unit at present so skill mix can be an issue, but this will improve as new staff integrate into the unit and gain further knowledge and skills." (neonatal service)

6.33 When describing concerns about skill mix, many staff referred to the perceived changes in patient profile and acuity in a short space of time. Rates of planned caesarean section and IOL were felt to be markedly higher, with women undergoing such intervention needing enhanced care; this view is broadly corroborated by the increase in caesarean sections set out in section 3.



6.34 The profile of the neonatal and maternity workforce has changed significantly over the last five years, with the departure of several highly experienced and longstanding staff members. Some staff told us that they feel the shift to a less experienced team has impacted the well-established profile of neonatal nursing. We heard that "the nurses voice is lost in discussion on the unit" and "team-working amongst senior clinical staff is positive, but it is non-existent with a large majority of junior staff." Overall, most staff acknowledged that, over time, a healthier balance between experienced and less experienced staff is likely to be restored across both services. In the meantime, skill mix for upcoming 72-hour shifts is reviewed during the daily huddle held in each service.

6.35 Midwives who have been qualified for less than 5 years rotate between the different parts of the maternity pathway to develop and maintain their skills. Midwives with 5 or more years' experience have a 'core' location but also need to work in other areas to evidence maintaining midwifery skills. We heard that, whilst there can be pockets of resistance to rotating out of a 'core' location, most staff recognise the importance of maintaining key midwifery skills, particularly to support the overall service during periods of escalation.

6.36 There is a perceived disparity in workload and responsibility amongst some staff in the neonatal team; the Band 6 nursing workforce was highlighted by several staff we spoke to and in the survey comments. An example comment here was, "having a large number of junior staff on shift with a large number of babies or sick babies puts a lot of pressure on Band 6s…It is not uncommon for those senior nurses to take on more workload than they should, due to the more junior nurses not yet having the appropriate skills to care for particular babies."

6.37 We understand that an organisation-wide review of job planning commenced in early 2024. In maternity, this work has been led by the Clinical Director of Obstetrics and Gynaecology in collaboration with other members of the senior leadership team. The review revealed that some consultants did not have job plans, while others were working from significantly outdated ones. It also identified a substantial gap between the number of planned and required consultant sessions. We were told that there is now a clearer understanding of medical workforce capacity and where additional support is needed. For example, middle-grade medical cover on triage is lacking and will need to be addressed for the service to fully realise the benefits of BSOTS in triage.

6.38 Feedback about neonatal job plans was more positive, but we were told that the key medical workforce challenge over the past 12 months has been in relation to junior doctor rotas following negative feedback from staff. The neonatal service runs a 'Consultant of the Week' from Monday to Friday, and we heard that this approach works well.

6.39 There is also a current focus from the senior leadership team on out-of-hours, on-call rosters. The current approach in maternity is to have a resident consultant at night. There was broad agreement in interviews and focus groups that this model does not use consultant job plans to best effect. We also heard concerns that it can undermine development opportunities for trainee doctors as there can be a tendency to default to the consultant on call.

Focus on Triage

- The crucial role that triage plays in the quality and safety of care women receive was underlined throughout all aspects of this review. Often described as the emergency department of maternity services, triage is a vital service for pregnant and newly postnatal women who need care outside of scheduled appointments. Reasons to attend can vary but can often relate to concerns about baby moving less, bleeding and being in labour.

- We heard from women, however, that accessing responsive and compassionate care via triage was not always possible. Triage outcomes and performance have not been a clear and consistent part of operational oversight and assurance reporting across or out of the service.
- The challenges of providing safe, supportive care to women in the busy clinical setting of triage is not a challenge that is unique to SBUHB. In recognition of this, the RCOG published guidance in December 2023 recommending several requirements including that all maternity triage units adopt BSOTS.
- The guidance set out how services should support women via phone, when to ask women to attend the unit in person, and the specific skills and experience that staff working in triage should have. It sets the expectation that women attending a triage unit should be assessed by a midwife within 15 minutes of attendance. A symptom-specific algorithm is used to assess the woman's level of clinical risk which guides subsequent care and medical review. BSOTS is designed to ensure that all women who contact triage are assessed and treated based on clinical need.
- The Health Board launched BSOTS in November 2024. Most staff we spoke to between January and April 2025 felt that the service is safer and able to provide women with a more positive experience as a direct consequence of BSOTS. Prior to BSOTS, it was not uncommon for the unit to be staffed with midwives who were redeployed from other areas of the maternity unit.
- The operating model for triage now includes mainly dedicated core midwives who only work in triage; this ensures that there is consistent in-depth expertise on hand for women in an emergency scenario. We were told that it can still sometimes be a challenge to ensure that all shifts include triage-specific staff – understanding and addressing risks to the staffing model underpinning BSOTS will be crucial to the Health Board realising the safety benefits that BSOTS offers.
- Many staff spoke to us about medical cover in triage remaining an area of fragility. The RCOG guidance paper sets out the recommendation for minimum staffing levels in triage departments based on numbers of births per year. We heard that it is a frequent occurrence that that triage has limited medical cover at a registrar level with over reliance on GP trainees which undermines the service's ability to provide responsive senior clinical review for women. Further work is recommended on assessing patient flow and acuity with in-depth audit of telephone triage calls, attendances, time in the department and medical need.
- BSOTS guidance also covers the triage environment and division of tasks between staff on each shift. For example, it recommends that all telephone calls to triage are taken by a midwife whose duties at that time are solely for telephone triage in a quiet confidential space. The Health Board does not currently have a dedicated telephone triage midwife and utilise one of the two midwives on duty who have competing demands with the initial assessment and ongoing clinical care elements. This impacts on the ability to triage within the 15-minute standard, the quality of telephone care and the safety of women in the department.
- Our review of recorded telephone conversations with women, who accessed the triage telephone line provided an insight into the quality of calls. Staff appeared to lack confidence and general telephone skills to promote assurance to the woman she was being given the correct information. Women repeatedly reported that staff made them feel a "nuisance" when calling and that they were dissuaded from attending. Further work is required to standardise the evidence-based information given to women and utilise the recorded calls for learning to improve the quality of the calls.

- When attending in person, the guidance recommends that units have a seated waiting area which is "ideally visible to clinical staff." Some units have been able to redesign the physical layout of triage units, including dedicated phone booths for midwives to receive telephone calls without possible distraction or interruption, and clinical office space which has direct line of sight to the waiting area so women can be observed in between clinical review for signs of deterioration. The physical layout of triage at Singleton has not allowed the service to fully implement all aspects of the guidance.
- At the time of writing this report, we understand that the service is undertaking an evaluation of BSOTS to understand its overall impact on care, outcomes and experience and to assess whether further changes are needed.

Training and education

6.40 The care delivered by staff in maternity and neonatal service, particularly for a level 3 NICU, is contingent on having staff that have the right training, experience and support. This is best achieved through:

- effective clinical supervision and practice reflection to process experiences;
- training that keeps staff up to date with contemporary practice, core skills, and the needs of the people they care for; and
- staff having the time and resource to train, to reflect, and to understand the needs of those for whom they are caring.

6.41 There are several challenges facing maternity providers as they seek to ensure a pipeline of qualified staff to meet the demand and needs of their populations. A recent RCM publication[73] highlights:

- growing numbers of students leaving midwifery courses before they graduate;
- high numbers of senior midwifery educators leaving their profession; and that
- better support is needed for student midwives during their training to meet the high standards expected of them.

6.42 The gap between what people expect when they set out to become a midwife and what they experience is also significant and plays a part in the recruitment and retention challenge faced by providers. Across the UK, there are also high attrition rates in the first two years after qualification (when graduates are referred to as 'newly qualified midwives' (NQM)), as well as high rates of burnout and stress in the NQM workforce.

6.43 There is a growing body of research that suggests there is a need for providers to be more alert to the needs of newly qualified midwives as they transition to practice. Recent published research[74] indicates that the support this staff group receives as they become embedded into the workforce is crucial to continue their education and identify gaps in skills, competence and confidence. The disparity between expectation and reality can be a challenge for some NQMs. Support can range from sufficient supernumerary time and a well-structured preceptorship programme, mentoring, structured rotations, to joining a supportive and compassionate team.

6.44 The Maternity and Neonatal Conversation Wales Report 2023 also stresses the need to address weaknesses in undergraduate training, improve support for students and newly qualified staff, and strengthen "recognition of different generational needs in education." The report sets out the challenges associated with a decline in student numbers, alongside the loss of "skilled and experienced staff."

6.45 Although focused on England, the CQC review of maternity services 2022-2024[75] provides relevant context for SBUHB and the challenges facing the maternity workforce in Wales more generally. The report states "there is work to be done to future-proof the workforce and attract students to a career in midwifery, as data from UCAS shows midwifery applications for June 2024 were at their lowest for more than 6 years."

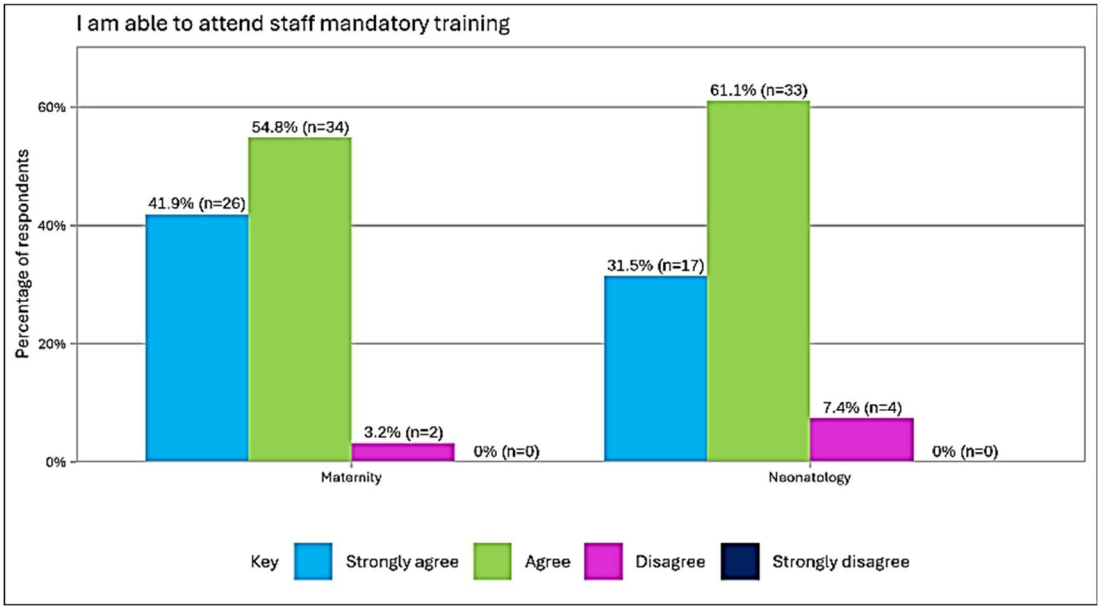
Findings

6.46 Mandatory training for staff includes neonatal life support, basic life support, governance and safeguarding. From early 2020 and largely due to the impact of the pandemic, maternity struggled to ensure all staff completed mandatory training. This was raised as an organisational risk at the time with a score of 20 (very high risk) and continued to be discussed as one of the service's top three risks until last 2021.

6.47 Concerns about mandatory training compliance were reiterated by the HIW following their September 2023 inspection and have since received significant focus from the service and wider organisation. Both services can demonstrate notable improvements in compliance against mandatory training requirements. At April 2025, The Health Board's Enhanced Monitoring report showed that compliance with mandatory training requirements ranged between 85-93% depending on the staff group; the Welsh Government target is 85%.

6.48 The Mandatory and Statutory Training Framework and the Induction Policy are currently under review by the Health Board.

6.49 The staff survey results also reflect the positive picture in relation to mandatory training being made available:



6.50 Many staff told us about weekly professional update sessions for midwives. Topics covered in these sessions include diabetes, bereavement, mental health and supervision. There was much support for this provision, but several staff felt that their impact could be greater if staff from other professions across the perinatal pathway could be invited.

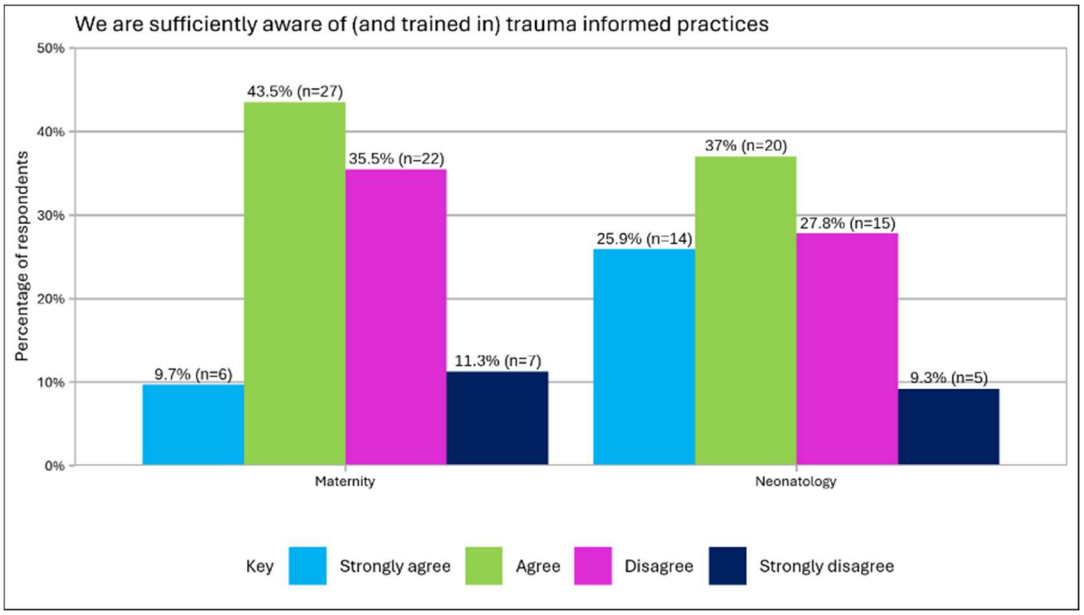
6.51 Perinatal teamworking is a key feature of the Maternity and Neonatal Safety Support Programme (MatNeo SSP) report, with the report stating, "teams that work together should train together." PROMPT focuses on emergencies that can arise during childbirth. Effort is made to ensure that this training is truly multi-professional; staff from both services told us this is highly effective when it happens, although noted that this was not always possible in

practice. It is also notable that paramedics from Welsh Ambulance Service Trust (WAST) have attended training sessions alongside community midwives.

6.52 We heard, however, that obstetric attendance at PROMPT sessions can be low and interviewees were not clear about who was the obstetric lead for PROMPT. Further findings associated with obstetric capacity and the implications this has on perceived engagement, are outlined later in this section.

6.53 Local newborn life support training is another area in which the Health Board is aiming to bring staff from maternity and neonatal teams together. Like PROMPT, there is the intention to run sessions for maternity and neonatal staff to train together, but capacity has not yet allowed this to happen on a systematic basis. Staff spoke to us about their appetite for more trauma-informed training. There were numerous comments in our staff survey about the need for trauma-informed care training in the context of supporting women both after an episode of care and in preparation for future pregnancies. There are small numbers of staff in both services who have undergone trauma-informed training, as well as ad-hoc support provided by staff who work outside the services, but it was clear from staff that there is a perceived gap between the needs of women and families and the skills of staff in both services.

6.54 The same issue applies to staff and several people we spoke to felt that there was more to do to avoid staff experiencing vicarious trauma stemming from witnessing a traumatic event. People we spoke to agreed that staff are well supported in the aftermath of a significant adverse incident. Recent examples of this in practice have included group supervision, supporting staff to receive counselling, regular check-ins from line management and adaptation of caseload. Nevertheless, several felt that the compassion and care colleagues display would be significantly enhanced if more staff received trauma-informed care training.



6.55 There is more to do to ensure training and education offered in both services address factors that underpin team working and a positive safety culture. Some steps towards this have been made recently; for example, there has been a focus over the past year on providing incivility training, and we understand that this will continue throughout 2025, with an increasing focus on professional behaviours. This was in part driven by HEIW feedback in early 2024 regarding instances of incivility and bullying. We would suggest that, given the feedback elsewhere in this report from women and families, as well as findings associated with learning from adverse events, this work needs to be scaled up to ensure all staff receive the same messages about behaviour, attitudes and human factors.

6.56 The Clinical Supervisor for Midwives and the Practice Education Midwives have also been working to support the wellbeing of staff and promote positive team working, such as by gathering feedback from student midwives to identify areas in which they need more support. We heard, however, that a key barrier to this work developing at pace is the capacity of the Practice Education team. There is not, for example, a retention midwife, which can be a valuable role in supporting staff on rotation, returning to work, and implementing actions arising from feedback from trainees.

6.57 Several people also told us that there is a need to understand the different roles, skills needed, and pressures that are inherent to the different roles that work in a perinatal service. We understand that there are plans in early development to include a spotlight on 'a day in the life of' different professions in practice development sessions.

Learner experience

6.58 The Health Board has strong ties with local universities, such as Swansea University, with staff in both maternity and neonatal teams working closely with and often delivering parts of education programmes.

6.59 Health Education and Improvement Wales (HEIW) is the strategic workforce arm of NHS Wales and is responsible for oversight of training, recruitment and retention of all NHS staff in Wales. HEIW undertake targeted visits at providers to identify areas of strength and improvement for people who are training.

6.60 HEIW have undertaken three visits between February 2024 and April 2025 and reviewed the provision of postgraduate medical training in obstetrics and gynaecology. The initial visit in February 2024 noted several positive aspects of the trainee experience in obstetrics, such as "a supportive culture where trainees felt comfortable seeking advice." It found, however, that a third of antenatal clinics lack consultant supervision and highlighted that "decisions made by trainees in clinics, such as admitting patients for induction, were sometimes changed on the ward." Supporting trainees during the management of IOL is also a recurring topic throughout this report. Feedback from trainees on service culture highlighted some isolated instances of undermining behaviour, but the report stressed that "such occurrences were not frequent and did not reflect the department's overall culture."

6.61 The most recent visit, in April 2025, concluded that the service has made several notable improvements to the experience of medical trainees, resulting in a reduction in the risk rating applied by the HEIW to the Health Board. Key improvements highlighted include:

- the quality of professional inductions;
- access to clinics;
- support from and access to consultants; and
- support to engage in clinical audits and quality improvement initiatives.

6.62 In maternity, there is a Doctor's Forum to which all trainees are invited, and this provides the opportunity to raise concerns and share ideas. The most recent HEIW visit in 2025 praised the progress made to support the learning and wellbeing of trainees.

6.63 In the neonatal service, there is a Resident's Forum which several resident doctors we spoke to found to be a helpful opportunity to discuss issues relating to teaching, induction, and staff wellbeing. Participants include postgraduate supervisors, consultants, and the Neonatal Clinical Lead. In May 2025, the Resident's Forum discussed the results of the Resident Doctor and ANNP survey to which there were five respondents. Areas of concern included ensuring consistent consultant presence at postnatal ward huddles.

6.64 The Clinical Supervisor of Midwives and the Practice Development Midwife are currently gathering feedback from student midwives. Feedback is being sought from those who have just joined the Health Board, from those who have recently transitioned from being a student to newly qualified midwife, as well as from students who attend specific training sessions, such as the session on responding to traumatic birth experiences. We have not seen the output of these evaluation exercises.

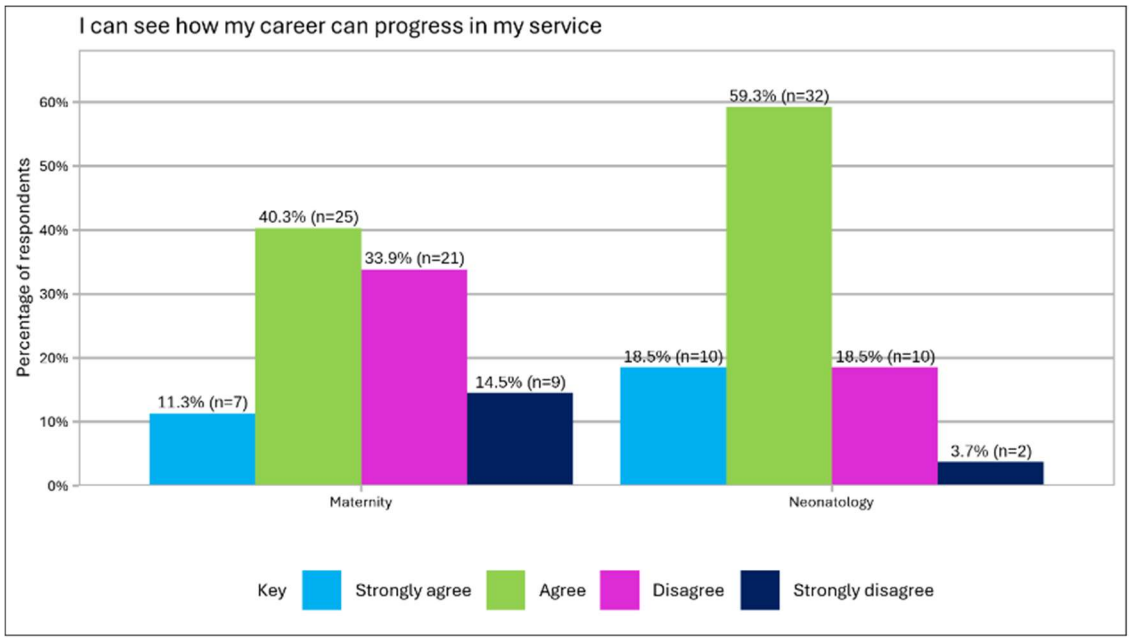
Career progression and development

6.65 We heard numerous comments to the effect that staff in maternity feel that the current leadership team are committed to and passionate about supporting individuals to develop their skills and explore specialist interests. The Clinical Director of Midwifery, Consultant Midwife and Clinical Supervisor were repeatedly singled out as particularly influential on the professional development of the midwifery workforce.

6.66 The creation of the Maternity Care Assistant role two years ago was highlighted by some staff we spoke to as a positive step to further develop the range of roles within the service, and an enhancement to the care women and families receive.

6.67 Staff from both services lamented the lack of proportional increase in continuing professional development (CPD) hours for support staff, particularly those who are newly qualified. We heard that there has been a lot of transition in the Practice Education team in maternity which has weakened the support available to staff. Since early 2025, there has been more stability with substantive appointments being made for practice educators, but there is still the need for 1 WTE Clinical Supervisor of Midwives.

6.68 In the neonatal service, staff repeatedly told us that there is positive support from the consultant body to identify areas of further development and interest. Survey feedback from neonatal staff about access to career progression was, overall, positive. Despite this, there were numerous free text comments, as well as comments made to us during focus groups and service visits, indicating that career progression is an area of frustration. We heard that staff felt that the pathway to progress their career beyond Band 6 was unclear and inconsistent. For example, some told us that leading a quality improvement project was essential to grow your career, whereas others felt that other areas of specialism should be recognised.



6.69 As explained earlier, the maternity service is creating roles within the Band 5 and 6 midwifery workforce, to support the services offered by specialist midwives. This is a positive step towards supporting the specific interests of practitioners, identifying those staff who may be part of future succession plans, and expanding the capacity of support in specialist areas.

Leadership

6.70 Failures of leadership are a consistent component of reports published over recent years on maternity services. Specific factors that reoccur are:

- a lack of coordination and tendency towards the reactive;
- poor medical engagement alongside incivility and disrespect between different professional leaders;
- a lack of investment in senior strategic roles;
- churn in leadership roles; and
- a lack of corporate leadership from provider organisations to maternity services.

6.71 The RCM's manifesto on 'Strengthening midwifery leadership[76] makes the case for elevating the role of Directors of Midwifery within organisations, as well as strengthening the role of consultant midwives as a vital conduit between leadership and front-line care delivery and expanding the range and capacity of specialist midwives to provide expert advice to women, families, and colleagues.

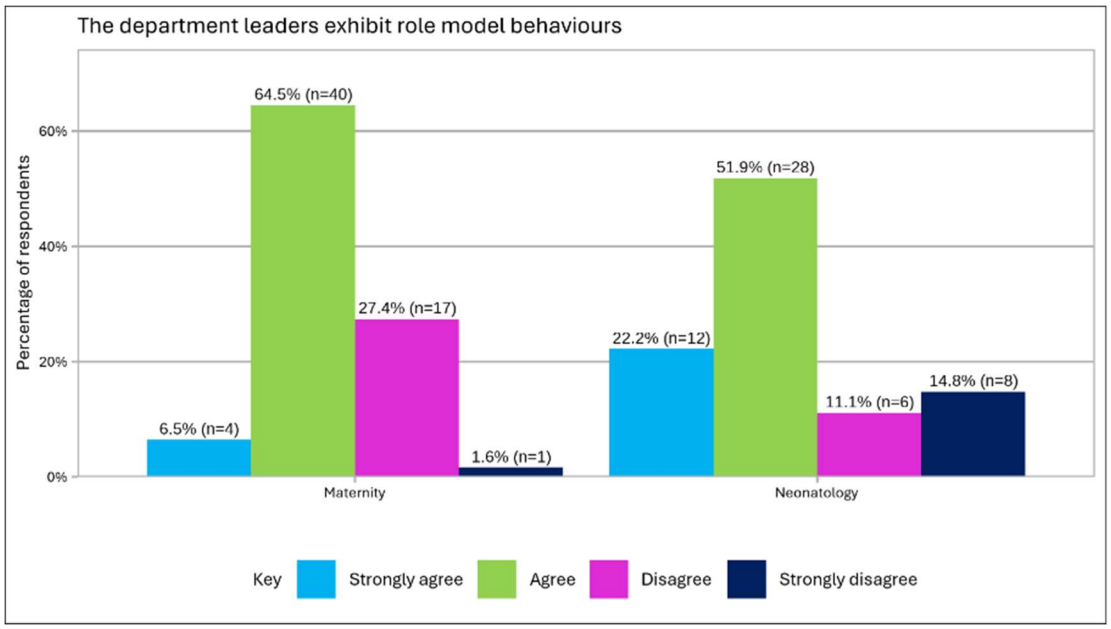
Maternity Services

6.72 Prior to 2024, there was a high degree of turnover in key service-level leadership roles within maternity such as Head of Midwifery (HoM), Deputy HoM, and Service Manager. Leadership instability was cited as a limiting factor in the service's ability to respond effectively to the 2023 HIW inspection, as well as embedding learning from other external reviews published between 2021 and 2023. This meant that opportunities for sustained improvement and cultural change were limited.

6.73 There have been material changes to the maternity leadership over the past 12 to 24 months, notably:

- The creation of the post of Clinical Director of Midwifery in July 2024 and the appointment of a highly experienced individual to this post. This post is supported by a Head of Midwifery (HoM) and a Deputy HoM.
- Significant investment in community midwifery leadership with the creation of eight Band 7 leads for the corresponding community teams, compared to six previously.
- The addition of a new Lead Midwife for Quality Improvement, a post which is also replicated in the neonatal service. Both provide operational leadership to the quality, safety and governance agenda.
- New appointments in 2024 included a new Clinical Director of Obstetrics and Gynaecology and an Obstetric Governance lead role.

6.74 Maternity staff spoke positively about their confidence in service leaders today, highlighting the way leadership role-models professional behaviour. Staff also reported feeling well-supported. Throughout our fieldwork, there was a clear and growing awareness among staff of whom to approach within the maternity leadership team. However, the service would benefit from periodically reinforcing this information through regular staff communications.



6.75 The positive impact that the Clinical Director of Midwifery has made over the past 12 months is substantial. Staff morale was described as significantly improved and staff told us that the Clinical Director of Midwifery's visibility and responsivity have been a source of reassurance. Leaders at a Service Group and Health Board level also lauded the appointment of the Clinical Director of Midwifery as a turning point in the service's improvement journey.

6.76 It was evident throughout our work that the pressure and expectation on the Clinical Director of Midwifery are significant. It appeared, at times, that stakeholders at all levels would benefit from a more nuanced appreciation of the complexity of improving the maternity service to avoid an over-emphasis on the Clinical Director of Midwifery being seen as the single point of failure or success.

6.77 There is also scope for a more visible multidisciplinary team (MDT) approach to representing maternity. Board meetings, for example, are attended by the Clinical Director of Midwifery who provides an update on improvement progress. Improved visibility of other members of the leadership team, including those in the neonatal service, would signal a united and collaborative leadership team.

6.78 There is a need for more engagement from the obstetric consultant workforce in the leadership of the maternity service; several people we spoke to felt that the current capacity of the obstetric team does not allow them to function as strategic leaders within the service. There are a small number of highly engaged consultants, including the Clinical Director of Obstetrics and Gynaecology, who are widely described as providing positive leadership to the service. The apparent willingness of others in the medical workforce to support work that contributes to the leadership and improvement of the service is low. Examples include covering work when those with assigned additional roles are on leave and attending key meetings such as the Obstetric Clinical Risk Meeting (OCRIM).

6.79 Staff described a maternity service that, until late 2024, felt reactive and lacking vision with many making the link with the interim nature of leadership posts and weak coherence between maternity leaders. This, they told us, resulted in a service that felt constantly in a

state of stress with unclear priorities, inefficient operational responses, and a lack of ambition. A statement from one interviewee that typifies the message we heard consistently from staff was “it is vastly different today.”

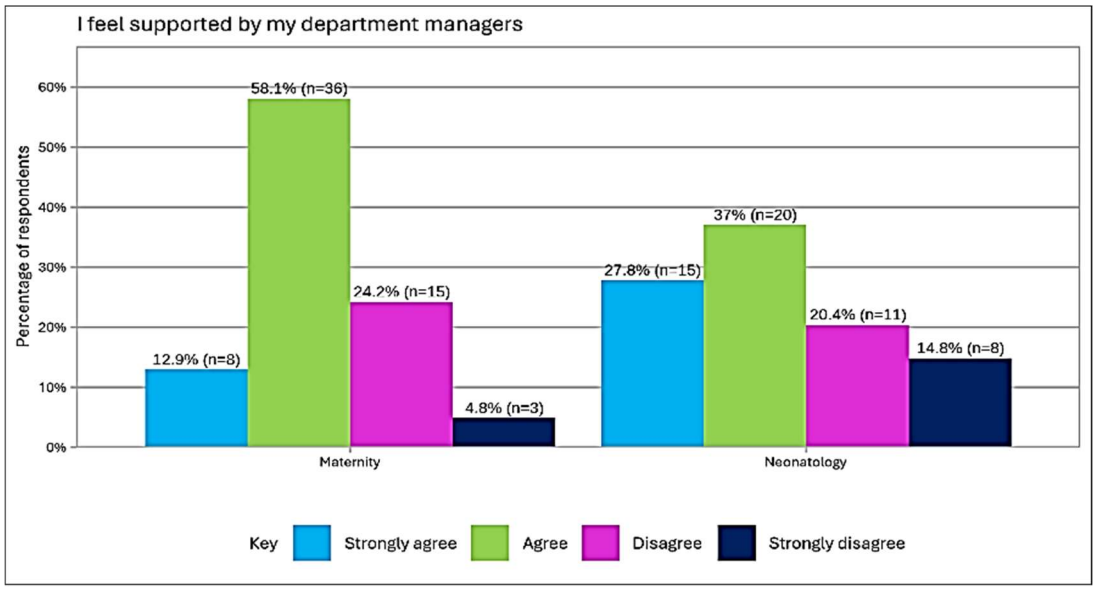
6.80 There is recognition that there remains a heavy workload to realise the ambitions set out in the Welsh Quality Standards, but the sense of optimism, shared vision, and confidence in leadership were palpable throughout our work.

Neonatal Service

6.81 There was resounding support and praise for the leadership provided by the Clinical Lead, their predecessor and the wider medical workforce including ANNPs. Staff told us that they feel there is a strong and shared quality improvement ethos amongst medical leaders and that this provides a strong foundation for staff development, identifying issues and areas for improvement, and fostering a sense of energy and purpose for staff working within the service.

6.82 Comments which were reflective of feedback from most staff we spoke include:

- “The Clinical lead is an excellent role model. She is fair, approachable and professional [..] and considers all views and approaches.”
- “Band 7 ward managers are approachable and supportive.”
- “One of the strengths of this department is the MDT working whereby any member of the team regardless of role can speak up.”



6.83 Feedback was more mixed, however, in relation to other aspects of leadership within the service. We heard that:

- the Band 7 nursing workforce feel disconnected from the senior leadership of the service;
- staff do not feel that there is parity of leadership between doctors and nursing. In part, this was attributed to the loss of several highly experienced, long-standing neonatal nurses, but it was felt to be reflective of current dynamics; and
- there is an appetite for more appreciation to be displayed from some members of the senior leadership team for the hard work and discretionary effort of staff, and to celebrate success more.

6.84 The overall picture presented in the staff survey in relation to leadership is positive, but there were a concerning number of comments which referred to perceived unfairness and incivility stemming from neonatal leadership:

- "There is no appreciation of staff changing shifts or staying late."
- "There can be a lack of compassion for their staff…we have lost many excellent nurses because of this, because of a lack of flexibility without good reason, lack of compassion and poor leadership."
- "It is very clear that managers have favourites within staff."
- "[Some leaders] do not empower staff equally, do not manage more difficult staff well leading to unfairness and resentment, and often focus on areas of criticism without recognising achievements."

Corporate Leadership

6.85 We have examined corporate leadership at Board and Service Group levels. Service Group leadership is the conduit between the Board and the service and has seen significant change in personnel over the past two years. The capacity and expertise to support and oversee maternity and neonatal services has been bolstered by the appointment of an Associate Service Group Director and Associate Service Group Medical Director in mid- 2024.

6.86 Unlike Trusts/Foundation Trusts in England, Health Boards are not required to have a **Board-level Safety Champion.**[77] Since 2017, Trusts and Foundation Trusts in England have been mandated to appoint a Board member, typically a non-executive director, with dedicated responsibility for maternity and neonatal services.[78] This role acts as a corporate conduit between the Board and frontline services.

6.87 Where this role has been executed effectively in England, Boards have access to the voice of staff and generally have an improved insight into the day-to-day reality of working in services. Both the maternity and neonatal departments can be seen as distinct services which are not directly comparable to other services within an organisation. Having a Board member with specific understanding of this context can strengthen the maturity of Board-level oversight. The depth, nuance and impact of discussions can be improved, including unblocking non-clinical issues such as estates and IT issues, as well as the support provided to prominent roles such as the Clinical Director of Midwifery.

6.88 Prior to July 2024, the connectivity between the Board and the service was limited. The appointment of the Clinical Director of Midwifery was a key turning point in elevating the Board's insight into care for women and babies in the community and in hospital. The Clinical Director of Midwifery reports into the Executive Director of Nursing & Patient Experience which is in line with 2021 guidance relating to maternity leadership issued by the Royal College of Midwives[79].

6.89 Since the HIW inspection in September 2023, frequent 'open access' meetings have been held between members of the Executive team, and services. Initially these were held on a weekly basis, but this has been reduced to every 2-3 weeks based on staff feedback. The opportunity to ask questions, raise concerns, and engage with corporate leaders has generally been welcomed by staff we heard from.

Culture

6.90 Organisational culture describes the shared ways of thinking, feeling and behaving in an organisation[80]. Reports in response to care failings in maternity and other services have repeatedly highlighted a service or organisation's culture as central to its ability to consistently deliver good patient outcomes and positive patient experience.

6.91 An open, questioning and supportive approach when things go wrong is vital to prevent a culture of blame from becoming dominant. Labelling staff as 'good' or 'bad' is counterproductive as, at some point, all staff are likely to make mistakes - this is inherent in any human system. However, in maternity care, such mistakes can have disproportionately severe emotional and physical consequences for the baby and family, often resulting in lifelong care needs.

6.92 A 'just culture' is one with fair accountability within an understanding of interdependencies, because this promotes safety. Individual accountability is still a feature of a just culture, but certain tests have to be met: a) was the individual intentionally acting outside of established guidance? b) was the individual acting in an impaired way? And, c) was the individual behaving in a reckless way and putting people at needless risk of harm? These are key questions which underpin any disciplinary process and support the application of a just culture.

6.93 Improving Together for Wales (2023)[81] (MatNeo SSP) says that "achieving psychological safety requires a flattened hierarchy and a learning system that creates an environment in which all team members can comfortably make suggestions [and that] anyone in the team can:

- ask questions without feeling stupid;
- ask for feedback without looking incompetent;
- be respectfully critical without appearing negative; and
- suggest innovative ideas without being perceived as disruptive."

6.94 Any person working in the perinatal workforce has chosen a demanding career which requires resilience on all levels. A midwife, for example, might move through a vast range of emotions on any given shift, from elation through fear, through (sometimes) sadness and grief. Many staff working in maternity and neonatal services, however, feel it is a privilege to work within their profession, and they describe helping women and families through life changing experiences as amongst the most satisfying parts of the role.

6.95 Perhaps more than any other healthcare discipline, midwifery in general has struggled to tackle the 'culture of blame' where there is an incident or accident at birth.[82] It is known that blame creates fear. Blame also creates a risk averse environment and gives rise to the potential for 'over-medicalisation' which in turn can mean that there is less focus upon the woman and more upon the process of birth.

6.96 When the focus shifts away from the women there is an inevitable impact manifesting in a reduced positive experience (section 4); particularly, that they feel unheard, discounted, and that staff are sometimes abrupt and unsupportive. Blame can also be (and often is) self-directed in this workforce group, with feelings of guilt and shame being commonly attributed to stress and burnout.

6.97 One small study undertaken in 2023[83] indicated that midwives frequently reported fear, particularly that the 'unpredictability of birth' drives risk aversion and cautious approaches to birth. This can in turn lead to increased (and perhaps unnecessary) interventions. Midwives often feel they are not able to provide the care that they were trained to deliver. This fear, set within the context of a very busy and unpredictable birth unit, potential staffing issues, and a culture of blame, provides a backdrop for the 83% burnout statistic amongst midwives in the UK; this is double the rates for the same cohort of professionals in Australia and New Zealand.[84]

6.98 According to the MatNeo SSP Cymru[85], for midwives to be able to deliver consistently great care, staff require the following:

- to work in high performing teams with good communication;
- to work in teams with safe staffing and mature approaches to recruitment, retention and training;
- to be supported to learn, and continuously develop; and
- to work in services and organisations which are well-led.

6.99 These characteristics have been more recently reinforced in the Quality Statement for Maternity and Neonatal Services[86] which states that for midwives to succeed, particularly to provide compassionate and safe care, they must be able to work in a compassionate and psychologically safe environment themselves. In reality, this means working within a culture which promotes civility, kindness and respect, where leaders exhibit role model behaviours and the organisation provides the tools, equipment and training required for people to be able to deliver a high standard of care.

6.100 **Compassion fatigue** can arise as a direct consequence of burnout. It is a well-known concept in mental healthcare provision and regular psychological supervision is put in place to try to combat the effects of 'the emotional cost of caring' upon staff. Compassion fatigue amongst midwives and maternity staff is receiving more attention alongside more focus on trauma within the workforce. It has been described as a "...state of significant depletion or exhaustion of the nurse's store of compassion, resulting from repeated activation over time of empathic and sympathetic responses to pain and distress in patients and in loved ones." The consequences of compassion fatigue can have direct consequences on patients with "changing behaviour and loss of the capacity to interact and engage intimately with others for whom they have responsibility."[87]

6.101 The Strategic Perinatal Workforce Plan for Wales was approved in April 2025. Central to the plan is "strengthening leadership and workplace culture by creating safe, supportive environments, embedding compassionate leadership, promoting continuous learning, and evaluating clinical supervision to support professional growth." So much of an individual's experience of care in maternity, or when their baby is being cared for in neonatal services, is relational. This means that a focus on culture is particularly important.

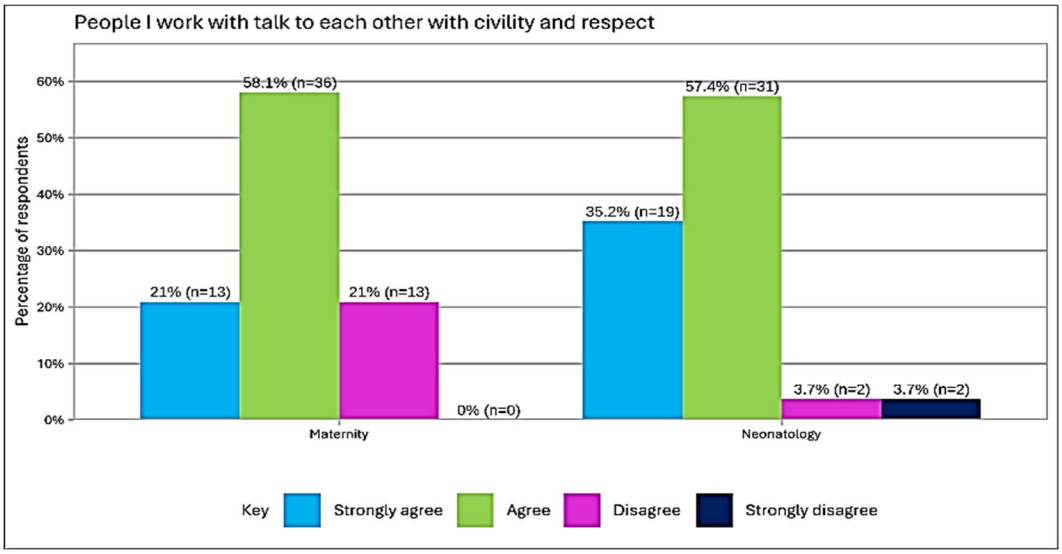
6.102 The work of midwives can often involve experiences of secondary or vicarious trauma, for example, after involvement in a traumatic birth. Staff support in this area of healthcare is vital. **Compassionate mind training** has been found to be beneficial in clinical groups for individuals who report symptoms of primary trauma, low levels of self-compassion, and who are self-critical[88].

Findings

6.103 Our multiple interactions with staff made it clear that, overall, people feel supported and part of a team. This finding was consistent across survey data, interviews, focus groups, and service visits. We heard:

- "I am proud to be part of this team." (neonatal service)
- "There is good collaboration between maternity and neonatal teams." (maternity service)
- "Teamworking is excellent. We are all compassionate people with the desire to make birthing people's experiences the best as we possibly can." (maternity service)
- "I have witnessed many of my colleagues going above and beyond for a vast majority of our patients." (neonatal service)
- "There isn't a hierarchy and everyone is approachable." (maternity service)

6.104 Positive teamwork, sense of belonging, and mutual support are key foundations of a culture orientated around psychological safety. What we heard repeatedly and clearly from staff representing all professions in maternity was, overall, very encouraging.



6.105 We heard that people feel drawn to staying at the Health Board and continuing their careers after qualification. Several consultants we spoke to in both services described waiting for a post to become available and many we spoke to had undertaken part of their training at the Health Board. We were struck by the number of staff we met who described the Health Board as one of the friendliest and supportive they have worked in.

6.106 The medical workforce (doctors and ANNPs) were universally described as passionate, engaged leaders, highly skilled, cohesive and, fundamentally, supportive of an MDT approach to clinical decision making. Multiple staff told us that the medical workforce are welcoming of new ideas and professional challenge. However, handovers, particularly in the neonatal department, were identified by several staff we spoke to, as inconsistent. Reviewing and agreeing an approach here is seen as an important part of ensuring team communication works as well as intended.

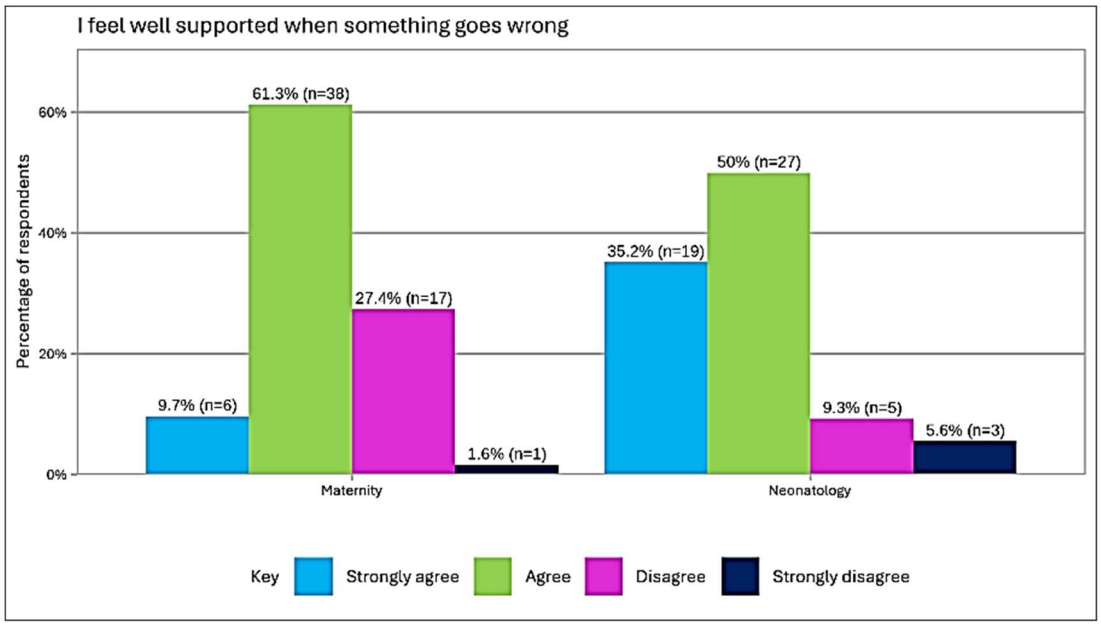
6.107 Throughout our fieldwork, the neonatal medical workforce consistently presented as a unified leadership group with shared values, priorities, and team-working. In contrast, we heard that there is too much reliance placed on a small group of highly engaged individuals within the obstetric team. Examples of what this looks like in practice include: the same two or three individuals attending governance meetings (such as OCRIM); inconsistent and sometimes absent representation of the obstetric workforce in perinatal meetings and cross-service processes (such as ATAIN reviews); and low engagement from obstetricians in multidisciplinary training (such as PROMPT).

6.108 Encouragingly, we consistently heard that there are positive working relationships between maternity and neonatal teams, both ‘on the ground’ and at a senior leadership level. These relationships will provide a strong basis from which to develop a more coherent shared vision and culture for both services.

6.109 However, there are still some areas in which cross-speciality, cross-site and multidisciplinary working need to mature and optimise the strength of shared intent, described by so many staff, to create a seamless perinatal service for women. These include:

- Enhanced obstetric engagement and representation in key pieces of shared work, such as ATAIN reviews.

- Developing a true perinatal approach and vision to combat tension stemming from different staff groups having different priorities. Put simply, women and babies can be perceived as a separate rather than biological unit by midwives and neonatal staff.
- Deeper insight into 'work as done' rather than 'work as imagined'[89] between services to understand priorities and pressures.
- Consciously ensuring that services are not overly Singleton-centric. We heard examples of maternity service development that had failed to meaningfully incorporate the views of Neath Port Talbot staff. This will only exacerbate any challenges posed by operating a service across a wide geographical patch.
- Working with radiology colleagues to ensure that capacity gaps that create risk to service provision and quality are understood from all angles and appropriately identified within the Health Board.
- We heard that staff in both services do not fear raising issues, concerns and new ideas. We found strong indications that both services have the foundations for an enabling environment that learns rather than blames when things go wrong, and embraces suggestions for improvement:



6.110 The strength of feedback about raising concerns cannot be overstated and sends a strong signal that most staff feel that they will not "be punished or humiliated for speaking up with ideas, questions, concerns or mistakes."[90.] Examples of how staff viewed raising concerns or reporting when things had gone wrong are:

- "I've never worked anywhere where incident reporting is so encouraged and responded to so well."
- "I feel that the Health Board is making a big effort to support us staff when incidents occur."
- "I feel very confident with the reporting system and feel supported to report all incidents."
- "I feel safe and supported to escalate any issues."

6.111 Fostering a positive reporting culture in which staff do not fear blame is a huge asset to maternity and neonatal services at the Health Board. The consistent and clear confidence expressed by staff that they would not face punitive responses was evident across all

engagement activities, despite several barriers including: adverse media/social media coverage, the 'climate' around maternity services across the UK and an approach to investigating incidents that does not centre on the system in which staff are operating (see section 7).

6.112 Staff have access to the Guardian Service which is an external, independent service offering staff a safe and confidential mechanism in which to raise concerns or risks, including those linked to patient safety. The Guardian Service works with 43 organisations in total, all of which are health and care providers. We saw evidence of the service being well-publicised in clinical areas. Since early 2024, representatives from the Guardian Service have been undertaking additional 'drop in' sessions in maternity to support staff following the HIW inspections and the announcement of the Independent Review. Regular meetings are also held with senior leaders, including the Clinical Director of Midwifery and the Head of Midwifery, to provide anonymised feedback and highlight any themes. We were told that the service is responsive to any concerns raised.

6.113 Monthly reports are produced by the Guardian Service and are reviewed by the Workforce and Organisational Development Committee. There would, however, be benefit in strengthening the triangulation of themes identified by the Guardian Service in maternity alongside other sources of data relating to staff engagement and concerns. We would expect, for example, this information to be used at a service and Service-Group level to monitor changes that are made because of contact to the Guardian Service. We are also not aware of drop-ins being undertaken in the neonatal department, which we suggest should be considered to ensure neonatal staff feel there is parity of support, and in the light of the wider findings in this section.

6.114 The period following the raising or reporting of an issue is an area for development in both services. There was broad agreement that, when a significant adverse event occurs, learning is shared promptly to ensure that any immediate 'make-safe' actions are effectively communicated.

6.115 The 'Risky Business' newsletter was also welcomed as a means to share learning. However, most staff who engaged with us said that the learning process could still be improved. A common piece of feedback was that follow-up communication to staff members who raise an issue is not consistently provided. Staff emphasised that their willingness to speak up is reinforced by clear communication and visible signs that issues are considered thoughtfully, systemically, and openly. This issue was reported across both services; however, it was more prevalent from those in maternity. Staff told us:

- "I feel feedback is lacking and action on what I reported is sometimes not followed through."
- "Not enough feedback about incidents both generally and in response to an incident."
- "[Incidents] are submitted frequently but little detail is provided or feedback to the reporter."

6.116 Providing consistent feedback on issues raised and incidents reported is crucial. Staff need to feel that there is a positive impact to taking the step to speak up; otherwise reporting apathy may develop. We heard, however, that it is not uncommon for feedback to a staff member after they have reported an incident to be vague, superficial or non-existent.

6.117 The Health Board's insight into the views of staff in this area is weak. National staff survey data does not provide service-specific insight and thus far, the Health Board has not undertaken specific quarterly 'Pulse' surveys or the equivalent in services. Given this, we suggest that the Health Board implements the BAPM recommendation to undertake an annual psychological safety survey across all staff working in perinatal services91.

7

7. Governance

Summary

What are the key issues?

Between 2021 and 2024 there were significant weaknesses in governance. These related to a lack of challenge and scrutiny from Board members and poor visibility of issues relating to maternity and neonatal services. The maternity service was overwhelmed with: overlapping action plans; confusing governance meeting structures; blurring of roles; poor recording of meetings; siloed committees; poor risk management; weak development and revision of clinical guidelines; and an absence of a clinical audit plan prior to 2025.

Responses to harm events are typically poor. There has been: a lack of access to timely and compassionate debriefs following birth; a lack of acknowledgement from the Health Board and an absence of unreserved apologies, including a commitment to learn; and poorly written correspondence lacking compassion.

Incident investigations need to improve. There is an overdependence on the role of the 'governance midwife', and there needs to be an urgent move to establishing multidisciplinary panels. There has been a lack of involvement of families in investigations, such as PMRT and serious incident reviews.

Complaint handling in maternity and neonatal services is poor with: a significant backlog; poor investigations; a lack of timely compassionate responses; limited learning and improvement; and inadequate assurances to Board. This has contributed to a lack of oversight of key risk areas including those identified with triage, paediatric radiology, delays in fetal pathology and scrutiny of MBRRACE-UK and HIE data.

There is an overreliance on more positive assurance from feedback on women's experiences from the Maternity Voices Partnership and 'family and friends' surveys. The testimony of women who have had very poor experiences is not being heard, particularly those experiencing birth trauma.

What is currently in place?

There are new senior leadership and Board positions since 2024. These include a new Chair, Chief Executive and Executive Director of Nursing & Patient Experience, and changes in leadership structures at a service group and directorate level including a new Clinical Director of Midwifery, Clinical Director of Obstetrics and Gynaecology, Associate Service Group Director and Associate Service Group Medical Director.

Responsibility for complaint handling has moved to the portfolio of the Executive Director of Nursing & Patient Experience.

Silver and Gold Command meetings focus on the action plans from the HIW report, with the latter being reported directly to each Board.

A Perinatal Committee has been established chaired by the Executive Director for Nursing & Patient Experience.

There has been improvement in data capture and the introduction of a maternity and neonatal dashboard to monitor service outcomes.

A limited debrief service is provided for families and a family engagement midwife has been appointed to support families. This is an area which needs significant improvement.

Family involvement is being improved in investigation processes and in providing feedback.

The Chair and Chief Executive have met a small number of families who have had a poor maternity experience; this needs to be continued

A clinical audit plan for 2025 has been approved.

What is being progressed?

Further development of the maternity and neonatal dashboard is underway to include more focus on the lived experience of women. Enhanced wider family engagement is being implemented to support this.

The Perinatal Committee is being further developed with a review and clarification of other meeting structures to support this.

Improvements are being made to investigation processes, inviting families to participate, but further improvements are needed to ensure families are at the centre of all investigations.

The involvement of obstetricians in perinatal mortality reviews is increasing.

What more is there to be done?

A complete review of governance processes and Board reporting for maternity and neonatal services, including escalation processes and the structure and terms of reference for some governance forums such as the Quality and Safety Group.

An urgent review of the organisation's response to harm processes, to include a full review of the complaints process.

Discussion with the Welsh Government about a review of the Putting it Right guidance and its implementation, which ensures families' engagement with this review.

Escalation of key issues to the Welsh Government, such as the shortage of paediatric radiology capacity and delays in fetal pathology.

Development and roll out of an education programme ensuring family-centred, compassionate and trauma-informed care.

Taking direct action where there are examples of incivility, rudeness and lack of compassion to both families and staff.

What are the immediate priorities?

- Ongoing review of governance processes and Board effectiveness for maternity and neonatal services.
- Review of policies and implementation.
- Urgent review of complaints processes and improved compassionate responses to harm.

Feedback from external reviews

7.1 This section considers whether the Health Board can demonstrate the capacity to implement and sustain improvement triggered by external reviews, of which there have been several in the past six years including:

- **Review 1:** June 2019 – HIW inspection, Maternity Unit at Singleton Hospital
- **Review 2:** October 2019 – HIW inspection, Maternity Unit at Neath Port Talbot Hospital
- **Review 3:** November 2020 – HIW National Review of the Quality and Safety of Maternity Services

- **Review 4:** May 2022 - Maternity and Neonatal Network Assurance Framework
- **Review 5:** August 2022 – Wales Maternity and Neonatal Network Maternity Services Governance Process Review
- **Review 6:** September 2023 – HIW inspection, Maternity Unit at Singleton Hospital
- **Review 7:** April 2024 – Follow-up HIW inspection, Maternity Unit at Singleton Hospital

7.2 It should be noted that all of the above apply to maternity and this section therefore predominantly focuses on the maternity service; however, we have commented on the application of actions relating to neonatal services where appropriate.

7.3 There are several findings in this Independent Review which can be traced back to the external reviews described above. We recognise that some of the issues found in the above reviews are complex and, at least in part, caused by external factors; we nonetheless found deficiencies in the Health Board's responses to the profound patient safety issues being raised:

- **The pace of change** – some issues highlighted by external reviews are long-standing, yet we have found evidence of improvement hard to identify until very recently. The lack of momentum is arguably a result of a period of instability within the senior leadership and wider workforce, which remained in flux until around 12 months ago. The global pandemic (Covid-19), led to interim leadership arrangements as well as significant staffing gaps which hindered the development of a workforce capable of driving and sustaining change.
- **An isolated response to issues** – we found a tendency for issues to be considered in isolation without a consideration of the system within which they have developed.
- **Weak governance processes** – we found that there is a disparate approach to the oversight of improvement actions, including a reluctance to use action plans which are reviewed systematically. We found myriad action plans rather than one single improvement plan. There is a need to strengthen the administration of improvement to ensure that effort is not duplicated, actions are not missed, and to improve the overall oversight of improvement.
- **Scrutiny of change** – we found that there is a need for more assurance to be sought on the impact of actions. There is a tendency for actions to be marked as 'complete' without adequate, managerial challenge, or, where appropriate, external testing. Action plans when drafted rarely contain outcome measures which would enable leaders to be assured that action has resulted in sustained change. Examples of recurring issues raised by external reviews are illustrated below:

Issue	Addressed in section:	Featured in the following review reports:						
		1	2	3	4	5	6	7
Using feedback from women and families to improve	4			✓	✓	✓	✓	✓
Clear, compassionate communication / language	4	✓		✓	✓		✓	✓
Record keeping / discussion about patient choice	4	✓	✓	✓	✓		✓	
Management of delays to treatment / induction of labour and pain relief	4						✓	✓

Good breastfeeding promotion and support	4, 6			✓			✓	
Safe staffing levels	6	✓	✓	✓	✓	✓	✓	✓
Effective access to care via triage and antenatal assessment unit	6						✓	✓
Training and appraisals / effective supervision	6	✓		✓	✓	✓	✓	✓
Effective risk management	7	✓			✓		✓	✓
Strong communication to and from staff	6	✓	✓		✓		✓	✓
Perinatal mental health support	5			✓	✓			
Accessible, clear, reliable performance reporting	7	✓	✓	✓	✓	✓	✓	✓
Up-to-date clinical guidelines	7	✓		✓	✓		✓	✓
Sufficient ultrasound capacity and capability	6		✓				✓	✓
Clear, effective escalation process	7	✓	✓		✓		✓	✓
Clinical audit, incidents and complaints drive improvement	7	✓		✓	✓	✓	✓	
A safe, clean and suitable environment / equipment	5, 7	✓		✓	✓		✓	

7.4 Maternity and neonatal services were placed under Enhanced Monitoring by the Welsh Government in December 2023 following the HIW inspection in September 2023 (see further below). Prior to this point, the monitoring of action progress was inconsistent and there was limited evaluation of the impact of actions taken. A range of factors contributed to this, including high turnover in leadership roles and staff shortages, which reduced the capacity of senior leaders to effectively oversee and drive improvements.

7.5 Between 2020-2024, we observed that the maternity service was overwhelmed by multiple, overlapping action plans. We consistently heard reflections from staff that, in hindsight, there was a clear need to align action plans to support sustained improvement. We saw simultaneous but uncoordinated efforts to monitor the delivery of HIW actions; respond to other high-profile reports on maternity services elsewhere in the UK; address issues identified by the MatNeo SSP in Wales; and ensure safeguarding processes were robust, considering concerns raised by the HIW. There was a sense of inertia created by 'action overwhelm.'

7.6 In February 2025, improvement plans relating to the HIW and HEIW were closed. The rationale for closure centred on the transactional delivery of actions, as opposed to a robust assessment of their impact. A review of the improvement plans revealed that the Health Board's interpretation of required actions was often vague or insufficiently defined, which in turn limited the ability to effectively assess the progress and impact of implementation.

7.7 Our assessment of actions from the 2024 HIW inspection is outlined in the appendix to this report. A significant amount of work has been undertaken since the inspection, however, we

found that there remains further work to do to fully address the deficiency underpinning the HIW recommendations, and to robustly assess whether improvement has generated the intended outcomes, if articulated. We understand, via minutes of the Quality and Safety Committee in May 2025, that there is the intention to use the Health Board's Audit Management and Tracking Tool (AMAT) to capture "evidence…to demonstrate the closure of actions" which we see as an important source of assurance.

Enhanced Monitoring

7.8 Enhanced Monitoring was put in place over maternity and neonatal services by the Welsh Government in December 2023. As part of the 'Enhanced Monitoring' programme there are several different meetings in place. One is a monthly meeting held with the NHS Executive - the part of Welsh Government with responsibility for strategic leadership, performance, and oversight of safety and quality across the NHS in Wales. On a quarterly basis, the Enhanced Monitoring meeting is replaced by an Integrated Quality, Planning and Delivery Meeting for all maternity services across Wales.

7.9 The purpose of the Enhanced Monitoring meetings is to provide[92]:

- continued oversight, to enable clinical teams to progress on their journey supported by quality improvement support;
- effective governance and programme management oversight to ensure delivery against the milestones within the maternity and neonatal improvement plan in line with set trajectories;
- peer support; and
- awareness of the work programme and outputs of the Independent Review.

7.10 The terms of reference for Enhanced Monitoring set out a comprehensive set of metrics that the services have been required to report against monthly. These metrics have been incorporated into a standing report. This requirement has been a key turning point in the governance of maternity services. We found that, prior to this point, the service's governance framework was disparate; there was no cohesive system in place for a single, integrated view of performance, safety outcomes, activity, workforce and quality.

7.11 Additionally, under Enhanced Monitoring, the Health Board introduced a range of time-limited oversight meetings including:

- **Silver Command** – Chaired jointly by the Clinical Director of Midwifery and Associate Service Group Medical Director, this forum is for service-level leaders to meet, present the status of all maternity improvement plans and for the pace of delivery and outcomes to be scrutinised.
- **Gold Command** - Chaired by the Health Board's Deputy Executive Medical Director (the Acting Medical Director at the time), this is the forum in which the Service Group leadership team (Clinical Director of Midwifery, Associate Service Group Director, Group Nurse Director and Associate Service Group Medical Director) is held to account for the delivery of improvement actions. Gold Command reports directly to the Health Board. Agendas are standardised and focus on the de-escalation criteria to exit level 3 Enhanced Monitoring (see below), delivery of external action plans, learning from national reports (such as MBRRACE-UK) and the management of open incidents and complaints.

7.12 A review of the minutes for the Silver and Gold Command meetings shows that the quality of reporting and depth of analysis have steadily improved during 2024 and into early 2025. It was noted by several staff we spoke to that Gold Command meetings have been instrumental in providing a clearer direction as to which improvement areas to prioritise, and more visibility

of the status of overall improvement. However, we found that there is a need for more systematic scrutiny of evidence that shows action taken has resulted in an intended outcome; this is a recurring theme throughout our assessment of Health Board governance. The introduction of AMAT in 2024 (a digital tool to capture actions and link to improvement outcomes) should help the Health Board in this regard.

7.13 The introduction of the three forums above, because of Enhanced Monitoring, has substantially strengthened the grip and oversight of improvement actions needed in maternity, and to a lesser degree, in the neonatal department. Prior to this point, there was an inconsistent and somewhat disparate approach to the oversight of improvement. We were also told that the Health Board's approach to Enhanced Monitoring meetings has been proactive, open and transparent, particularly under the leadership of the Clinical Director of Midwifery.

7.14 There has also been a marked improvement in the quality of data provided in the latter part of 2024 and early 2025, particularly in relation to the range of metrics and detail associated with key quality improvement initiatives. There is further scope, however, to include more forward-looking analysis. In recent months, we have seen increasing use of 'run charts' (a line plot of data over time). Expanding this type of analysis will further strengthen reporting and service-level insight into performance trends.

Additional forums for oversight

7.15 Alongside the key forums above, a range of additional service-level improvement meetings have been established, including a MatNeo SSP Assessment and Action Plan Meeting (established June 2024), a Perinatal Forum and a Maternity and Neonatal Improvement and Assurance Board. Concerns were raised at the start of our review that there were too many forums in which the subject of improvement was being discussed, resulting in both confusion and duplication. The role and scope of the Perinatal Forum particularly, was the source of confusion for many we spoke to.

7.16 More recently, we heard that the governance structure for improvement is becoming more streamlined. In March 2025, a structure diagram was produced which set out a single Maternity and Neonatal Improvement and Assurance Group which will cover MatNeo SSP, actions arising from this Independent Review, MBBRACE-UK actions and any requirements associated with the Enhanced Monitoring process. We understand that this will report to a Maternity and Neonatal Quality Assurance, Performance and Improvement Group, chaired by the Executive Medical Director.

7.17 There would be significant benefit in communicating the revised governance approach for improvement to all staff, to ensure there is shared understanding of roles, responsibilities and decision-making routes. In the light of the findings set out in this section, we also urge the Health Board to harmonise improvement actions, with a greater emphasis on evaluating outcomes – rather than the completion of tasks.

Directorate and service group governance arrangements

7.18 Until Spring 2024, there was a separate Women's Health Directorate which included maternity; neonatology sat separately in a Children and Young People's Directorate. Today, the services sit together within the Children, Young People and Women's Services Directorate. Staff reported little difference to day-to-day collaboration between maternity and neonatal staff from the change in early 2024 and stated that relationships continued to work well in that regard.

7.19 The intention behind combining the services under a single division was to enable opportunities for a more joined-up approach to the oversight of perinatal services which,

prior to 2024, were largely separate. This objective has not yet been realised; there is still a tendency for maternity and neonatal services to be considered separately which reduces the benefits of joined-up approaches (this expectation is now set out in the 2025 Quality Statement).

7.20 Reporting and escalation routes out of the service to the division and service-group have generally lacked clarity, consistency, simplicity and efficiency for the period covered by our review. This was evident in our interactions with senior staff, many of whom expressed reservations about how effectively this aspect of the Health Board's governance framework worked.

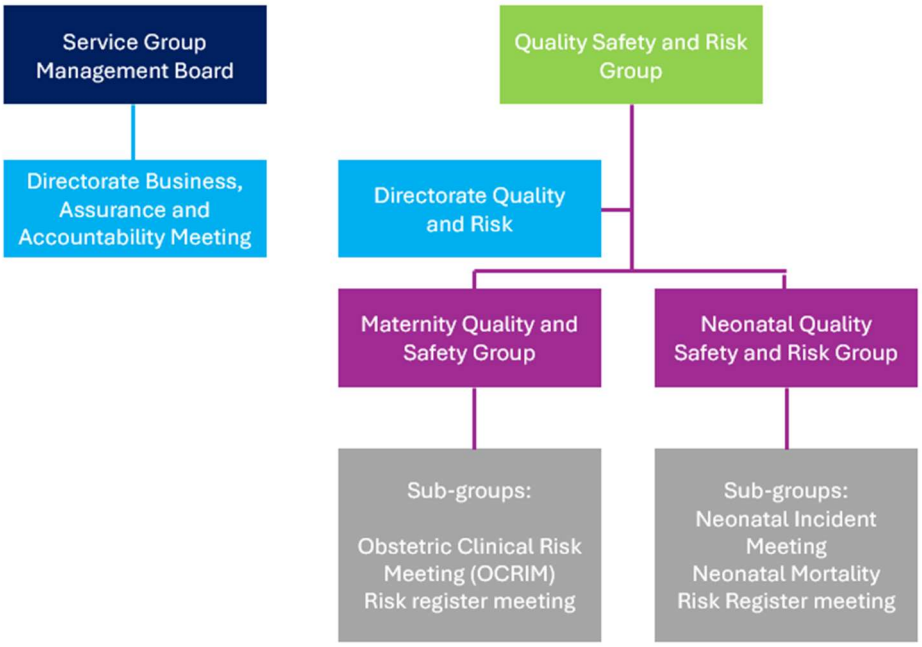
7.21 Oversight responsibilities are divided between business and performance, managed through a directorate-level Business, Assurance and Accountability Meeting (which reports to the Service Group Management Board) and Quality and Safety Group, which are overseen via a directorate-level meeting that feeds into a Service Group-level forum. Several staff reported that that this structure provides fragmented oversight of performance with duplication, gaps in escalation, and blurred reporting lines. Recent slides presented to an Enhanced Monitoring Meeting featured complex organisational diagrams with multiple reporting pathways from service-level meetings upward. These diagrams were not consistent with how many staff described the actual functioning of reporting and escalation processes and there is a risk of confusion.

7.22 A review of agendas of directorate and Service-Group governance forums from 2021 onwards indicated that limited time was given to maternity and neonatal services due to the number of competing departments in the directorate and Service-Group portfolio. This remains a challenge, and it is imperative that the Health Board ensures that the topics covered in these meetings are not lost before the cessation of the Enhanced Monitoring programme, when several forums may be retired. Minutes are also brief; for example, minutes reviewed of the CYPWS Quality, Safety and Risk Group from Spring 2025 capture no evidence of discussion, probing or triangulation and simply state, "report shared and noted" against most items. Given the importance of this forum in the Health Board's oversight of quality and safety, we would expect more evidence of scrutiny and impact.

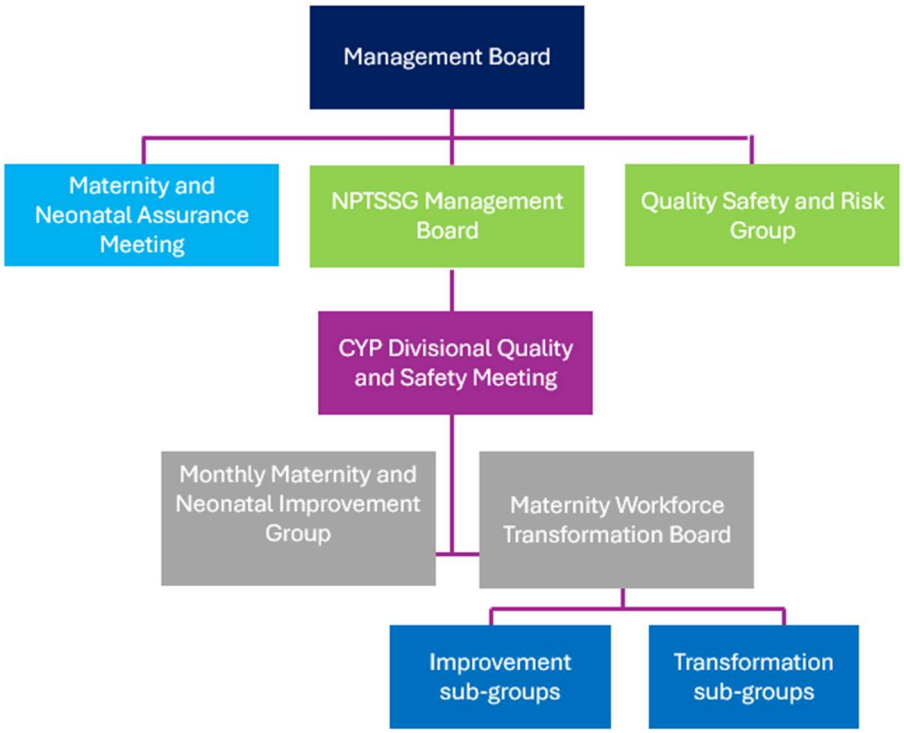
7.23 In May 2025, the Health Board outlined its intention to establish an assurance-focused Perinatal Committee which will report directly to the Quality and Safety Committee and the Management Board. This will be supported by a Perinatal Assurance Group which will sit at a Service-Group level, and a Perinatal Delivery Group will operate at a service-level. We have been unable to review terms of reference underpinning this structure as they are under development. The concept of strengthening and clarifying Board-to-ward assurance is one that we support and the need for simplicity and renewed clarity in this approach is evident.

Service-level governance arrangements

7.24 We have illustrated below the 'business-as-usual' forums that have been in place during most of the time covered by this review.



7.25 It was evident that the structure remains in a state of flux and the Health Board has provided its most recent structure in the Enhanced Monitoring Report of May 2025 (see diagram below). It was described differently by many members of staff we spoke to, and we also found that agendas, minutes and terms of reference for some of these forums, such as the Quality and Safety Group, had varying names and lacked clarity and detail on how each forum interacted with other parts of the governance structure.



7.26 In addition to the internal arrangements described above, the Neonatal Service conducts a quarterly performance management meeting with representatives from the NHS Wales Joint Commissioning Committee. As part of its governance relationship with the Committee, a dedicated quarterly oversight forum is held to review key performance indicators and safety metrics. This structured engagement introduces an added layer of independent scrutiny, which, at present, provides a more robust and consistent mechanism for assurance than that solely achieved by the Health Board's internal oversight processes.

7.27 Our review of service-level Quality and Safety Group meetings between 2021 and early 2024 found:

- Inconsistencies in the approach to governance of safety between the two services; the agendas, membership, and focus of these meetings varied significantly.
- Quality and safety included data on a range of topics but focused on case management, as opposed to themes and trends that could drive learning.
- Meetings frequently discussed safety briefs that needed to be issued in the light of learning from individual incidents and concerns. There was, however, limited evidence that issuing safety briefs targeted the systemic issues underpinning an incident. This is explored further later in this section.

7.28 In maternity services, the Obstetric Clinical Risk Meeting (OCRIM), which occurs every two weeks, is the principal forum for the multidisciplinary review of clinical incidents. However, a review of meeting minutes from 2021 to 2023, alongside consistent feedback from staff, indicates that the effectiveness of OCRIM has been limited by low levels of engagement from the wider obstetric workforce. Participation has largely been confined to the Obstetric Clinical Lead and the Governance Lead, and a broader range of obstetric voices must be included.

7.29 The administration of OCRIM has also been notably weak during this period, reflecting ongoing and acknowledged capacity challenges within this area. As a result, meeting documentation has at times been unclear, incomplete, or lacking in sufficient detail. It was not unusual for meetings to be cancelled, adding delays to the review of incidents. This is particularly concerning given the central role OCRIM plays in supporting the service's ability to scrutinise incidents, extract learning and drive improvement. Current records often fail to capture required levels of scrutiny, for example, several recent incidents have been presented without any identified care or service delivery issues, contributory factors, or learning; yet these omissions have not been questioned or explored by those in attendance.

7.30 We requested sight of documentation associated with the weekly Neonatal Incident Meeting, but we were told paperwork is not maintained for the meeting; instead, the Health Board's incident reporting software (Datix Cloud IQ) is shown on a screen during the meeting. It has therefore not been possible to assess the overall effectiveness of these meetings, including quality of scrutiny, action orientation and attendance.

7.31 We found that there was a blurring of governance roles and responsibilities between meetings held as part of the Health Board's governance structure, and the Maternity and Neonatal (Clinical) Network[93] (the network). The network seeks to bring together representatives from all key professions and Health Boards across Wales to support the delivery of safe, high-quality care and ensure services are aligned to national priorities, such as the Quality Statement. We found that there was insufficient connectivity between topics reviewed as a network, such as mortality and HIE, and other aspects of governance managed internally. The impact of this is that, until recently, key aspects of intelligence, learning and risk, was not joined up. This was a fundamental and serious barrier to the triangulation of all aspects of quality. The role of the network more broadly is considered later in this section.

7.32 Learning and assurance from mortality reviews is a key example here. Whilst there have been clear and established local processes for individual reviews at the Health Board, the outcomes and learning have been held by the network, who undertake oversight. We would expect to see the robust transfer of intelligence from the network back into meetings such as the service-level Quality and Safety Group; this was not the case between 2020-2024.

7.33 Services have largely recognised these issues during this review. As such, we understand that the structure is a work-in-progress and remains in a state of flux as we write this report. We have seen evidence that the following changes are under development, to improve the function and effectiveness of service-level governance:

- A perinatal governance structure is under development. As referred to above, this will have a high profile in the Health Board's overall governance structure, with direct reporting at Board-level. It will be supported by a sub-group structure and will review key topics such as rates of HIE and learning from ATAIN reviews. Terms of reference for this structure were not available at the time of writing, but we support steps taken to ensure a perinatal approach wherever possible and the strengthening of oversight of issues that span perinatal services, such as HIE, ATAIN and MBRRACE-UK.
- A perinatal mortality review and oversight process is also being developed. This will incorporate peer feedback from network mortality meetings. We have been told that this process is under development and as such, have not had sight of terms of reference. We have also seen recent evidence of maternity and neonatal deaths being scrutinised at the Health Board's Learning from Deaths Panel; this was not the case until early 2025 and marks an improvement in the Health Board's assurance in relation to service-level mortality governance. Further findings in relation to mortality review, including PMRT, are set out later in this section.
- A Maternity Services Experience Forum is being established. According to the draft Terms of Reference, the forum will collect and review "all aspects of patient experience…to remain responsive to the needs of those using the service." It is understood that the forum will consider data from a range of sources, including the Maternity Voices Partnership (MVP), the Friends and Family Test (FFT), the new NHS Core Questionnaire, and real-time feedback from operational leads about issues raised directly by women and families in clinical settings. We understand that the service is in the process of initiating a quality improvement initiative to analyse concern themes which will be overseen by this forum.

7.34 It is encouraging that the marked absence of a specific forum for understanding the experiences of women and families is being addressed. This forum should also be used to ensure the triangulation of concerns with other experiential data; expanding the forum's remit to include neonatal experiences; aligning the forum's activities with the objectives of the Perinatal Engagement Framework; and including membership from women and families with lived experience.

The impact of the Board

7.35 The role of the NHS Health Board in Wales[94] is to:

- act as the controlling mind of the organisation, being responsible for overall governance;
- have oversight of service delivery to ensure that services are safe, joined up and cost effective;
- bring together executive and independent directors with equal responsibility for ensuring the success of the organisation;

- enable independent members to support the Executive Directors, constructively challenging in order to achieve the best possible outcomes.

7.36 Direct reporting to the Board on maternity services did not start until February 2023. This increased oversight was driven by the publication of the MatNeo SSP Safety Support Programme findings, as well as the two external reviews of maternity services in England, namely the independent review of maternity services at Shrewsbury and Telford NHS Hospital Trust[95] in March 2022 and Reading the Signals: Maternity and Neonatal Service in East Kent[96] in October 2022.

7.37 We also found in our review:

- **The voice of women and families is not sufficiently prominent** – we found only infrequent examples of patient stories linked to maternity and neonatal services, and their impact was limited by a lack of follow-up discussion and the absence of complementary assurance, such as patient experience analysis, to provide necessary context.
- **Staff from the services are under-represented in Board and committee meetings** - it was rare for senior leaders from maternity or neonatal services to attend the Board or Quality and Safety Committee until August 2023. Since then, key leaders from each service have attended only to address specific agenda items, such as the reinstatement plan for community intrapartum services in August 2023, the maternity workforce transformation in September 2024 and, more recently in March 2025, the presentation of MBRRACE-UK findings.
- **There is a lack of visibility of maternity and neonatal services in the work of the Board** – work programmes from 2020-2023 did not include direct reference to maternity or neonatal services, whereas other services such as Children's Community Nursing were included for special attention. Work programmes for 2023/4 onwards do include some reference to services but this is very much in the context of a single perspective, such as progress against HIW actions. These reports tend to be brief and focus primarily on the number of actions completed and outstanding, rather than offering a holistic overview of the service, including assurance related to safety outcomes, activity levels, and staffing.
- **Board assurance is siloed** – there is no clear mechanism for the Board or its committees to triangulate single-focus reports with other indications of service safety and quality. A recent example of this is the Workforce and Organisational Development Committee looking at the neonatal recruitment and retention plan. We are not aware of how the Board has looked at the impact of this plan on outcomes for babies and families, or staff experience.
- **A historical lack of challenge and professional curiosity from Board members** – until recently, we found little evidence of questioning and challenge when matters relating to maternity and neonatal services were presented. Minutes reflect a Board culture that was overly accepting of reassuring statements and demonstrated a notable lack of probing of information presented. For example, the Quality and Safety Committee in January 2024 was told that there were "significantly improved [maternity] staffing levels following a highly successful recruitment campaign." There was no accompanying data associated with vacancies, fill rates, training compliance or absence levels, this information was not sought by the committees, nor was there any discussion about expected outcome measures that should be monitored to be assured that actions taken to strengthen staffing were having the desired impact on safety, quality and experience.

- **Ineffective escalation to the Board** – while it is standard practice across NHS Boards for committees to provide summary reports highlighting key discussions and escalation items, the effectiveness of this process relies on several critical factors: the accuracy and clarity of the report itself, the quality of the verbal presentation, the presence of subject-matter experts to provide context, and sufficient time on the Board's agenda for meaningful scrutiny. These conditions have not been consistently met at the Health Board in recent years. For instance, the March 2023 Board was informed by the Quality and Safety Committee that "maternity recruitment remained a national concern." This statement did not adequately convey the depth and urgency of discussion around staffing fragility, service provision challenges and staff morale.
- **Lack of predictive planning (within the system)** – risks in maternity services increase where there are capacity and demand pressures. In April 2024, the Singleton maternity unit saw a sudden spike in activity following the closure of the Princess of Wales unit for which SBUHB were given little notice. This led to increased incidents. Predictive demand modelling is a vital tool in planning for safety and ensuring that there are sufficient contingency plans in place to cover an increase in activity.

7.38 The Executive team convenes monthly as a Management Board, chaired by the Chief Executive Officer. Meetings have a comprehensive agenda that closely mirrors the work of the Board of Directors but without input and challenge from independent members. Our assessment of the role of the Management Board in relation to maternity and neonatal services aligns closely with our observations of the Board of Directors above. There is considerable opportunity to enhance the triangulation of intelligence. Currently, there is a disproportionate focus on action delivery with insufficient attention given to post-implementation evaluation. Moreover, the reporting, much of which duplicates what is presented to the Board and its committees, fails to offer a clear and comprehensive view of frontline services, particularly those identified as 'at risk' or under significant operational strain and external scrutiny.

7.39 The composition of the Board has undergone significant change over the course of the last 12 months. Key appointments include a new Chair, Chief Executive Officer, Executive Director of Nursing & Patient Experience, Executive Director of Planning and Partnerships, and Executive Director of Workforce and Organisational Development. We understand that the Board of Directors has recently engaged an external consultant to support a comprehensive Board development programme. With a more stable leadership team now in place, the Board is well positioned to strengthen its effectiveness and address longstanding challenges in its leadership and oversight of maternity and neonatal services.

Reporting on the safety and quality of services

7.40 At the highest level of the organisation, we found that reporting on the safety and quality of maternity and neonatal services is fragmented, often focused on single topics, and generally lacks theme and trend analysis. Standing reports (such as the Integrated Performance Report and the Patient Experience Report) tend to present data aggregated to a high level which limits the opportunity for the reader to identify 'hotspots' and early warnings. We recognise that Boards must strike a careful balance between providing oversight on both operational and strategic issues, but we would expect a much more distinct and proactive oversight of service outcomes, performance and experience.

7.41 The need to improve the Health Board's insight into the quality and safety of services has been well-recognised by the current leadership. For example, a perinatal dashboard has been developed; this is a key pillar of the Clinical Director of Midwifery's plan to strengthen the overall maternity quality management system. The metrics for inclusion in the dashboard

were presented to the Management Board in January 2025 and the dashboard is set to be operational from Summer 2025.

7.42 The proposed perinatal dashboard includes a range of metrics[97] that will be monitored at an operational level, alongside a more focused selection reported at a corporate/Board level. The development of a perinatal dashboard is a significant and positive step towards strengthening the reporting and escalation of quality and safety in maternity and neonatal services. However, there are a number of aspects of service quality and safety that the current suite of metrics does not cover. These include:

- **Patient experience data** – consideration should be given to the inclusion of experience measures as another insight into aspects of service delivery, such as birth choice.
- **Quantitative staffing data** – staffing is fundamental to the delivery of quality and safety. As outlined earlier, we found that reporting on staffing is frequently presented separately from intelligence on the safety and quality of services. Suggested metrics that could be considered include: percentage of shifts without registrar cover in triage and gaps in midwifery and medical rotas.
- **Performance metrics** – there are several areas where the current perinatal dashboard does not provide insight:
  - Triage is a key area of concern as outlined in section 4; coupled with the recent introduction of BSOTS, we suggest that metrics are included such as the percentage of women having a midwifery review within 15 minutes of admission to triage.
  - Data relating to escalation such as frequency of staff redeployment under the escalation policy.
  - Reporting on emergency transfers by ambulance between units and ambulance diverts should the maternity unit be at full capacity or closed. We found no routine reporting on ambulance diverts/transfers. We noted that in Autumn 2024, the Welsh Ambulance Service introduced the 'red phone' initiative which enables ambulance crews to forewarn maternity units about time-critical obstetric emergencies so that receiving teams are prepared for the patient's arrival. This is a dedicated phone line for a clinician-to-clinician discussion.
  - Ready access to information and monitoring of HIE cases is also required and this should form part of the new dashboard. This review found difficulty in obtaining data on HIE and, whilst analysis of HIE has increased significantly since 2023, delays in contemporary reporting (whilst case reviews are done etc.) because of validation processes means that the Board might not be aware of HIE issues and trends.

7.43 There is ongoing work at a national level to enhance the monitoring of maternity and neonatal services. The 'Maternity Beacon' initiative is centred on the development a perinatal dashboard that will allow for better benchmarking and Wales-wide oversight of quality and safety. This work is aligned to Digital Maternity Cymru, a five-year work programme which will see the implementation of a unified digital system, allowing for better capture and sharing of information between healthcare professionals. It will also enable women to have access to their own personal maternity record.

7.44 This national programme, however, may still take considerable time to implement. As it currently stands there are several IT systems used across maternity services in Wales. Neonatal services use Badgernet which is more conducive to benchmarking data between units. The service has, however, decided that a local dashboard should be developed while the national work progresses, such is the recognised need to improve reporting and escalation from service to Board.

7.45 During our review, we observed scope to strengthen other areas of reporting to improve 'line-of-sight' into services. These are set out below.

Women and family experience

7.46 Reporting in this area has and continues to lack triangulated analysis, and it is not possible for those working outside the services to identify themes and trends relating to how women and family experience services. Incidents, complaints and claims are all considered in isolation, and we saw no evidence that there is a systematic approach to triangulation.

7.47 From March 2025, expectant and new mothers have been asked to complete a questionnaire via text at different stages of pregnancy to understand what is working well and where care can be improved via the new NHS Core Questionnaire. The Health Board volunteered and was selected to be a pilot site for the NHS Core Questionnaire. It is planned that all Health Boards across Wales will adopt the same approach as part of the Perinatal Engagement Framework. This data will be invaluable to the Health Board's understanding of how women experience services.

Insight into demand and activity

7.48 Escalation of operational performance data beyond a Service Group level is rare and restricts the broader understanding of the pressures within which services are operating. Several neonatal staff shared their frustration in this area, particularly that there is a lack of recognition that the unit is classified as a 'level 3' NICU and receives referrals from special care units from other Health Boards. This has a direct impact on staffing requirements, the complexity of case mix and on MBRRACE-UK reporting which does not make an adjustment for case mix for level 3 units.

Staff experience

7.49 Until recently, limited intelligence has been shared beyond the service around staff morale, engagement, and wellbeing. While we acknowledge that meaningful work has been undertaken in this area both corporately and at service level over the past 12 months, there remains an opportunity to strengthen and standardise the reporting of this information to forums such as the Quality and Safety Committee. Examples of good practice in this area include: the inclusion of staff stories alongside patient stories; analysis of 'Pulse' survey data, including emerging trends; and greater representation from frontline staff in corporate forums.

Risk management

7.50 Between 2020 and late 2023, we found that risk management processes were often separated from the issues and concerns facing the services. For instance, although weaknesses in the service's escalation policy were discussed on several occasions during this period, and specifically highlighted by HIW during their 2023 visit, there was no clear evidence that these issues were considered for inclusion in the risk register. This, in turn, meant that decision making on risk was sometimes poor.

7.51 The approach to operational risk identification and management is now starting to mature although there are still gaps around the translation of emerging risks into action. Several staff in management roles told us that they feel there is increasing emphasis on risk management as a core part of service management, rather than as a separate, administrative task. Risk registers must be consistently shared with key managers, such as those at Band 7 and Band 8a, to centralise discussion on risk and increase the sense of collective ownership.

7.52 The overall risk profile of services is discussed on a regular basis in meetings such as the Maternity Quality and Safety Group, and high rated risks are now included in standing

reporting packs produced by the service for oversight meetings, namely the Service-Group Quality, Safety and Risk Group, as well as the Enhanced Monitoring Meetings. Both services hold their own monthly Risk Register meeting with input from the Health Board's corporate governance team to support consistency. The purpose of these meetings is: to identify and score new risks; review the status of existing risks; discuss mitigating strategies; and monitor the impact of actions to mitigate risks.

7.53 Through our review, however, we found issues of significant concern which are the subject of focus and discussion, but which are not being captured as material risks (see the table below).

Issues not translated into risks	Summary
Paediatric radiology	The Health Board's main paediatric radiology specialist retired in 2018 and since returned to work on a part-time basis; reports can be delayed, and we were told that it is not uncommon for the service to seek expertise on the individual's non-working days which is not sustainable. Whilst a risk related to paediatric radiology was raised on the radiology service risk register (sitting within a separate service group), there is no corresponding neonatal risk. These risks should, at the very least, be linked through Datix.
Delays in fetal pathology	There are national capacity constraints for fetal pathology with only one specialist to cover Wales. The impact of this is that perinatal postmortem results are taking 9-12 months against a national standard of 12 weeks. This also has implications for the timescale of mortality reviews and the sharing of findings with families. There is also a risk that someone may become pregnant prior to receiving the postmortem results which can impact care decisions for their current pregnancy. This risk is not included on the service-level risk register we were provided with in May 2025; we note that it is described as a risk within reporting to the May 2025 Enhanced Monitoring meeting.
Skill mix	This was the predominant concern raised by staff – see section 5. Both service-level risk registers concentrate on staffing numbers and do not reference the change in skill mix over the past 12 months, or the need for additional support including professional development that new members of staff require.
Equity in access to triage	Not only has triage emerged as a significant area of tension for women accessing services (and BSOTS has not yet been tested), there are also aspects of triage where there are risks around equitable access. For example, women who are using the Singleton birth unit, Neath Port Talbot FMU, or home birthing access a different triage approach and this can create operational blind spots.
Transitional care	Transitional care is provided on a ward for babies who need more care and monitoring than the routine care that babies receive on the maternity ward. It supports babies to stay with their mother rather than going to neonatal care. The staffing model in transitional care was raised by multiple members of staff we spoke to. Work has commenced to look at the operating model for transitional care; the risk that services carry until this work concludes has not been recognised on local risk registers.

7.66 The Health Board's Risk Management Policy, dated March 2023, uses a risk assessment grading matrix which identified the likelihood and consequence of a risk. We found several areas on existing risk registers where risks and associated scoring had not been updated to reflect the current position. For example, the implementation of BSOTS makes no reference to the ongoing audit work we heard is in place to assess impact and any need for adaptation.

7.67 Risks are escalated to an executive-led Risk Scrutiny Panel prior to inclusion on the Health Board Risk Register. There is a separate Risk Management Group which is chaired by the Executive Director of Nursing & Patient Experience and includes representation from each Service Group, as well as other roles such as Head of Patient Experience and Risk and Legal Services. The criteria for escalating a risk beyond the service level, either to the Service Group or to the Executive Directors via the Risk Scrutiny Panel, is not sufficiently clear and is not consistently applied in practice. Feedback indicated a wide range of perceived escalation thresholds, with scores varying from 12 (medium) to 20 (very high) used as starting points. This inconsistency underscores the need for enhanced guidance and education on the risk escalation process.

7.68 We have identified several risks within the Service Risk Register that are scored at 12 or higher and, therefore, meet the threshold for inclusion on the Health Board Risk Register. However, these risks have not been escalated accordingly. For instance, the risk associated with delayed induction carries a score of 16. This discrepancy highlights a misalignment between service-level and corporate-level risk management processes, suggesting a lack of integration and consistency between the respective risk registers.

7.69 Review of the Health Board's (corporate) risk register (see summary table below) over the period covered by the review's terms of references shows that there are some key risks that the Health Board has struggled to address for a sustained period. The HIW were critical of the extent to which the Health Board's risk register was used dynamically. They identified risks relating to maternity which had been identified two years prior to their inspection in 2023 which were still rated red or amber, having not reached the risk target reduction level.

Summary of maternity and neonatal risks on the Health Board's risk register

Year	Risk	Score
2021	CTG monitoring on labour ward	20
	Screening for fetal growth	20
	Delay in induction of labour	20
2022	CTG monitoring on labour ward	20
	Screening for fetal growth	16
	Delay in induction of labour	20
	Critical staffing levels	25
2023	Critical staffing levels	20
	CTG monitoring on labour ward	20
	Screening for fetal growth	20
2024	Inability to maintain BirthRate+ compliant rosters	16
	Screening for fetal growth	12
	Delayed induction of labour	12
	High quality choices in place of birth	16
2025	None (despite the profile of maternity services)	-

7.78 Review of the minutes of the Quality and Safety Committee found that there tends to be a superficial review of risks assigned to it from the Health Board Risk Register and a lack of scrutiny applied to their status and score in the face of other intelligence. For example:

- In March 2025, the committee discussed the MBRRACE-UK report 2023 which noted the need for improvements around CTG. Minutes capture an effective question posed by an independent member regarding the steps needed to reduce the risk associated with CTG which is currently scored at 20 or 'high.' The Health Board risk register presented to the same meeting makes no note of CTG, nor do minutes capture the omission.
- During the same meeting, the Risk Register report indicated that three maternity-related risks, specifically, the inability to maintain BirthRate+ -compliant rosters, fetal growth screening and the provision of high-quality birth setting options were downgraded to a score of 12 or lower and, therefore, would no longer be reported to the committee. However, there was no evidence that the rationale for this de-escalation was discussed or challenged, nor that any assurance was sought that risk-reducing action had been taken.
- The issue of de-escalation with minimal scrutiny and triangulation is not new. In December 2022, the critical staffing levels risk was reduced from 25 to 20 at the same time as the Workforce and Organisational Development Committee received a paper that outlined the significant and complex issues posed by critical staffing levels in maternity and "the need for significant improvements across maternity services to maximise efficiency, support the wellbeing of staff and improve patient care."

7.79 The role of the clinical network was raised on multiple occasions in relation to risk management, predominantly by neonatal staff. The consensus was that there are several risks which are not solely within the service's control and that the network has a joint role in reducing the risk.

7.80 We were told that the network has been through a high level of change over recent years and, as such, its role is not yet sufficiently defined, nor has it been able to have the impact that staff at the Health Board want to see. For example, we heard that the Health Board and other providers would benefit from a network-led digital cot-finder to improve the coordination and efficiency of neonatal transfers. Staff told us that this, and the associated risks to safety and timeliness of care for babies, has been raised on multiple occasions with the network with no indication of progress in this area.

The management of complaints

7.81 Under the Health and Social Care (Quality and Engagement Wales) Act each Health Board within Wales has a mandatory Putting Things Right[98] process which places a duty to promote openness and transparency when things go wrong. The statutory mechanism for this is through the statutory Duty of Candour which was introduced as a regulated activity in England in 2014, but the same duty was not introduced in Wales until relatively recently, in April 2023.

7.82 The Duty of Candour is more than a legal and statutory obligation; it is a trigger for cultural change. In November 2020, Health Inspectorate Wales (HIW) published its National Review of Maternity Services in Wales (phase one report) which was prompted by the reviews of maternity services provided by Cwm Taf Morgannwg University Health Board (CTMUHB). A significant feature identified in that review was the significant impact of women, parents and families' voices being ignored. Notably, it was thought that the lack of patient voice in the 'rounding' of care delivery led directly to the provision of substandard care.

7.83 The report into East Kent maternity and neonatal services found that the Trust did not acknowledge errors openly and try to learn from them, "safety investigations were often conducted narrowly and defensively, if at all, and not in a way designed to achieve learning."

7.84 In 2021, SBUHB started to implement a framework for engaging with women and families; this included a pilot via the Maternity and Neonatal Voice Partnership (MVP), a tried and tested engagement model. Whilst the MVP has become well implemented at the Health Board, there remain several fundamental issues with how women and families feel listened to and heard after a safety incident or episode of poor care.

7.85 When concerns and complaints are handled poorly by organisations, there can be a reinforcing effect in relation to the primary, or first-degree harm, now often referred to as 'a compound harm,' which research suggests can 'sometimes feel worse than the original harm itself'[99]. Compound harm refers to the harm that can be created after a safety incident, due to the processes that follow by "neglecting to appreciate and respond to human impacts" and is especially the case when people feel "unheard or invalidated."

7.86 The consequences of compound harm can be extensive and can worsen trauma symptoms causing nervous injury, enduring fear, and avoidance of using vital services in the future. Women who have experienced a premature birth are fifty percent more likely to experience psychological distress, and birth-related trauma or existing poor mental health conditions can leave elevated traumatic stress responses for many months or years after discharge. Links between induction of labour and trauma are becoming more pronounced and greater research is needed in this area.

7.87 Trauma and compound harm can result in intrusive thoughts and behaviours, emotional dysregulation, anger, sadness, and fixation. Trauma can limit one's beliefs about the future via loss of hope, limited expectations about life, or anticipation that normal life events won't occur[100]. Trauma causes significant pressures in different part of the healthcare system as people become more vulnerable to addiction, a lack of self-care and poor mental health.

7.88 If responses to trauma are not timely and not addressed in a deeply sensitive and compassionate manner, this can cause a pronounced exacerbation of the original harm.

7.89 Whilst acknowledgement of trauma and its impacts is increasing within NHS services, there is still a substantial inadequacy of response, particularly in relation to maternity, neonatal and paediatric cases where a specific type of trauma occurs[101]. Generally, the people who are directly involved in coordinating and responding to complaints have no detailed awareness of or training in trauma-informed practice. NHS Managers also have rarely received this type of training and a significant proportion of doctors, nurses and midwives (those directly on the front line) are not trauma informed.

7.90 This lack of vital trauma awareness and training can occur at the same time as staff may be experiencing compassion fatigue[102]. This occurs generally in caring professions (particularly mental health settings) which have prolonged exposure to trauma who can experience their own vicarious trauma as a result. Those symptoms are similar to those described above with numbing, disassociation, avoidance and emotional dysregulation.

7.91 Organisations too can become 'traumatised' on a wholescale basis and can be equally vulnerable to stress. Loss, dissociation and toxic stress can "spread like contagion" throughout an organisation. When this happens, it can become traumatised, unhealthy and distressed, which can result in practices that induce (rather than reduce) trauma, resulting in a trauma-driven culture[103]. This can lead to organisations operating in 'survival mode' which can dictate the way an organisation responds to families who in turn are expecting compassion, resilience and acceptance.

The roadblocks to saying sorry

7.92 In 2017, NHS Resolution produced helpful guidance applicable in England only, on 'saying sorry'.[104] This states that "not only is it a moral and right thing to do - it is also a statutory,

regulatory, and professional requirement. It can also support learning and improve patient safety."

7.93 In saying sorry there are both individual and organisational representations and reparations required. There are many reasons why NHS organisations can look evasive to a traumatised or bereaved family. There are a substantial number of blocks to providing the swift, honest and impactful responses which are needed. These might include:

- the volume and complexity of workload and the capacity of staff and infrastructure to address these (discussed in more detail later);
- the capability and training of staff who are responding to concerns;
- long waits for information, statements and access to other staff;
- a lack of reliable information;
- waiting for approval processes and sign-off at relevant meetings or committees;
- the involvement of legal processes such as inquests, Crown Prosecution Service cases;
- the involvement of trade unions or professional defence representatives; and
- investigations which are poorly conducted leading to a lack of reliable insight, prompting more questions than they answer.

7.94 When so many impediments exist to a prompt, open and accurate exploration of the facts, space can occur for feelings of mistrust, dehumanisation and powerlessness.

7.95 In December 2024 'Humanising Processes after Harm'[105] explored why 'compounding harm' occurs. The following key themes were identified as key features within the process:

- People needed to feel seen and heard and that they and their experiences mattered.
- People needed an acknowledgement of responsibility and an offer of repair.
- People need to be an equal partner in the search for the truth, particularly, they need to feel their views are factored into the investigation.
- People needed to see learning and improvement as the result of their case.
- People need flexible, timely support to feel safe in the world again. They often have a sense of internal conflict where they can get trapped in their own cycle of investigation, compelled to continue 'the fight' for their loved one.
- People needed honesty, openness and candour in a process they can trust which can be challenging when there has only been an internal investigation; people fear they have been denied 'real scrutiny.'

Achieving a just culture and restoring trust

7.96 To achieve a just and learning culture when care has not gone as expected or planned, three questions[106] should be asked:

- who is hurt?
- what do they need?
- whose obligation is it to meet that need?

7.97 In 2019, the Five Year Vision for the Future of Maternity Services in Wales was published and very recently (January 2025) the Quality Statement for Maternity Standards in Wales was issued as an update on that vision. The Five Year Vision includes the following ambitions:

- Where an adverse outcome has occurred, there should be a prompt investigation and multiprofessional review of the care provided (using the MBRRACE-UK national perinatal mortality review tool (PMRT)).
- The Health Board will ensure that the mother and her family are listened to, supported and have an active role in any review if they wish to do so. During this period, a named point of contact will be allocated (in the event of stillbirth or neonatal death this will be a bereavement midwife).
- All women who feel they require support after birth will have access to a formal debrief.

7.98 The Early Notification Scheme (ENS) was introduced in England in 2017 to prioritise investigations into birth injuries and to promptly resolve liabilities. The scheme specifically relates to babies born after 37 weeks with an enduring, non-congenital, severe brain injury (see further below on HIE).

7.99 The ENS is currently being evaluated but the process suggests that it has made a difference for families and for the NHS in their ability to apply openness, encourage learning, reduce defensiveness and seek early access to compensation. Importantly, as the legal process must be notified and commenced within 30 days of the birth, families have much more clarity on the steps towards remedy and redress. Without the ENS (or similar process), families who are already traumatised and bereaved, can spend years in an adversarial process with no guarantee of an admission of liability and no assurances on the future, in what is a heavily legalistic and not compassionate process.

7.100 Additionally, the Harmed Patients Alliance support the application of restorative and just approaches where "harmed patients and families are respected and cared for, their needs are understood and met, their suffering is minimised, and their recovery is supported, where preventable compounded harm is eliminated." They refer to a "Restorative and Just Culture that recognises and explains the complexity of how incidents occur, dignifies staff and harmed patients /families, and tries to put things right to the extent possible for people, between people, and in the safety system, using collaborative and inclusive decision-making processes that genuinely respect the harmed patient / family contribution. The starting point for such an approach is of course a commitment to honesty, transparency, and fairness."[107]

7.101 It is important to recognise that people simply want answers provided within a supportive environment, they need time to go through an iterative process of asking questions and understanding the answers (noting that a traumatised brain often hears and receives information differently). They often do not want to enter into an adversarial process but can be forced down that route by a lack of candour and lack of engagement. Sometimes the only way to be heard is to raise a formal complaint or to take legal action; a different, more humanising approach is desperately required.

7.102 The charity Action against Medical Accidents (AvMA) and the Harmed Patients Alliance have collaboratively engaged in a programme to develop a pathway approach for those who have been harmed, stating, "it is unrealistic to expect that a patient never comes to harm from safety incidents; what should be realistic is that if they do, this is quickly acknowledged, and responsibility is taken to proactively attend to the wide-ranging impacts on them to restore their wellbeing as much as possible." This is not supposed to be a binary or restrictive approach but should be used to ensure that restorative processes focus upon ensuring that no more harm occurs and that the process of healing can commence in a fundamentally patient-centred way.[108]

7.103 Developing and implementing this type of pathway would be a significant step forward in rebalancing the needs of an organisation to learn with the needs of the family for truth and accountability.

Findings for SBUHB

7.104 The findings set out in section 4 highlight the need for change in the approach to concerns and complaints management, both to ensure that learning is derived from any form of feedback, and importantly to avoid women and families being subject to 'compound harm.'

7.105 The importance of a compassionate and person-centred debrief was stressed in many of the conversations we had with staff. This was described as the starting point for many concerns; if debriefs work well, questions and issues that could be formalised in a concern are explored and dealt with locally. Indeed, the following experiences were described by women in their experience of seeking answers:

- "It would have been helpful to speak with someone at an earlier stage, to have information about how we could raise our concerns and for an offer of a debrief to be made. Opportunities should be offered to provide an explanation of how the situation became an emergency and why we were dissuaded from coming into the maternity unit."
- "Make the process clearer for questions to be answered. We have had to search for the right person and approach to resolve our concerns."
- "I experienced difficulties in finding out who to talk to about my concerns."
- "I have had no further contact or explanation of why this did not happen. More recently I attempted to follow this up as I still need answers to my questions about the traumatic birth."
- "I did get some answers to some of my questions, and they were predominantly clinical. However, I felt that there was a lack of quality in the process. There was a communications breakdown in that it was not clear when and how I would receive explanations. It was unclear whether any learning from what happened would be result in different ways of doing things in the same situation. I feel that women will continue to be unhappy if they have questions and there is no pathway for a response. I was lost in the system…"
- "There was no contact for around one year and I felt that without the debrief I would never have understood why choices and decisions were made."

7.106 Most maternity staff we spoke to acknowledged that there had been failures to offer and provide debriefs, particularly for women and families who have had an experience that was traumatic or significantly different to what they expected. The barriers to providing effective debriefs identified during this review include staffing pressures, skills and confidence of staff to provide an effective debrief conversation and identifying those who want a debrief and a time that best suits their needs. Therefore, the oversight of debriefs needs attention.

7.107 Data is not routinely and consistently collected and monitored to understand how many debriefs are undertaken. This would be valuable in assessing the demand for debriefs, understanding where and when women and families want to have a debrief, and identifying any ways in which staff need further support to provide effective debriefs. That said, it is the responsibility of all staff at every level to ask women about their birth experience, to provide advice and support and to signpost to further help if needed.

7.108 A consultant-led debrief clinic has been in place for a number of years and came under new consultant leadership in 2024. The clinic provides dedicated time to women and families wanting to reflect on their care. This is a positive example of work that the service has undertaken to improve the experience of women and families; however, there is more work to do. Several staff stressed to us that the capacity of the debrief clinic is limited and therefore it cannot be viewed as the principal mechanism for supporting women who want more information about their birth experience.

7.109 Significantly more action is needed overall to improve the impact of complaint responses, in particular, the tone, compassion and extent to which the essence of a concern is acknowledged. Many staff shared the view that there is more that the Health Board can do to ensure those who raise concerns feel heard and that concerns/complaints are used to influence improvement. The sincerity and passion to do this were evident.

7.110 A clear signal of this intent is the recruitment of a Patient Experience Midwife, which is planned for Summer 2025. However, the scale of improvement required needs consideration of skills and resource throughout the service, including but not limited to: coaching to staff who draft responses; review of the method used to review concerns; and enabling staff to have the time and confidence to reach out to women and families to check that a response answers their concern. Consideration should be given to expending this into a wider family liaison role to take more into account the birth partner.

7.111 We have analysed complaints over the period from 1 January 2021 to 31 December 2024. In total there were 283 complaints received over this period, with an average of 5.9 complaints per month received over the period. The number of complaints over the period appears to be increasing, with the rolling 12-month average number increasing from 5 per month in December 2021 to 7.3 per month by December 2024.

7.112 We reviewed a sample of complaints against the Health Board's policy[109] and identified consistent themes which echo the concerns raised by women and families where we found:

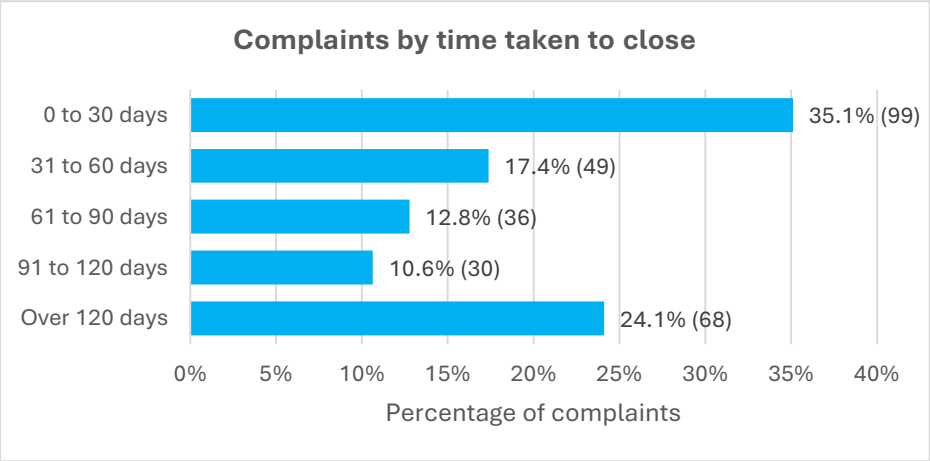
- **A lack of consistent open, honest and clear communication;** too often we found that responses to concerns and complaints were overly defensive, included the overuse of legal and clinical terminology, bombarded the reader with detail such as a multiple-page chronology of care, and lacked direct acknowledgement of the concern itself, which leaves women and families feeling unheard. Health Boards are required to include information in responses on how to make a claim under Putting Things Right Guidance, and this can feel at odds with setting a compassionate and personalised tone.
- **Sometimes ineffective investigations;** there is scope to improve the quality of the Health Board's review of a complaint. Some staff felt that there is an overemphasis on closing the complaint as opposed to learning from it, a view which is supported by the sample reviewed. The Health Board does not currently deploy systems-oriented methods to investigate its complaints or incidents.
- **A lack of timely and compassionate responses;** response letters are rarely provided within the 30-day timeframe stipulated by the policy, on average responses took 70 days. There will sometimes be cases which are complex and involve multiple stakeholders which could justify this timeframe, but the aim should be for a delayed response to be the rare exception rather than the norm. We saw multiple examples of women and families repeatedly contacting the Health Board to check on the status of their complaint. Efforts are now being made to sending women and families 'holding letters' to acknowledge the complaint and explain the delay as a matter of course; although this should not normalise extensions.
- **Limited learning and improvement;** most people who raise concerns and complaints want some assurance that something is being done to prevent the same issues reoccurring. Responses we saw rarely documented how review of a complaint has resulted in meaningful action being taken, nor did we see evidence of this in Datix or in the corporate reporting associated with concerns and complaints.
- **Insufficient quality assurance;** the Health Board has a long-established process to quality assure complaints responses. The corporate team for concerns/complaints logs all concerns received and undertakes a monthly quality audit of a sample using a

standardised checklist. The impact of this work is limited by the fact that it occurs after a response has been sent. We heard that the Health Board intends to revise its corporate quality assurance of the concerns/complaints process to be more proactive and able to intervene when a response sampled is below standard.

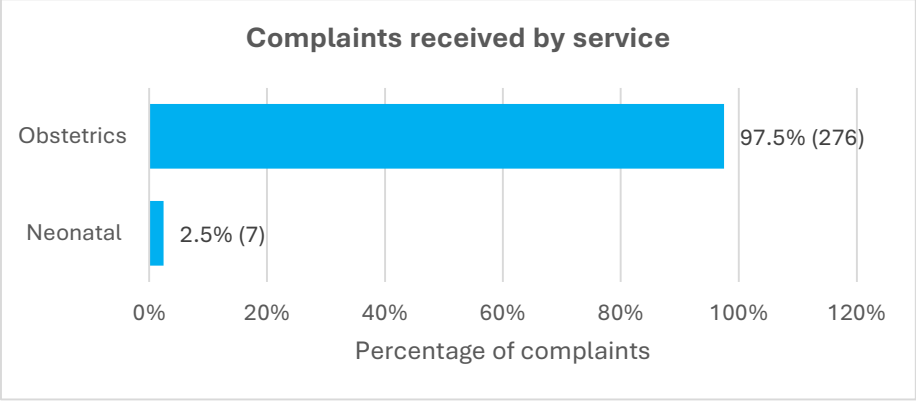
7.113 Whilst a Welsh Risk Pool review of complaints handling across the Health Board gave reasonable assurance when assessing the implementation of the Putting Things Right guidance, our review identified myriad weaknesses in the way in which concerns raised in maternity and neonatal services are handled.

7.114 Maternity has struggled with a significant backlog of complaints for several years. This lack of sustained improvement on response times has started to improve. The Health Board has a target of responding to 85% within an agreed timescale, a more ambitious target than that set by the Welsh Government (75%). Currently, the Health Board responds to 70% within an agreed timescale. In March 2025, maternity had 18 open complaints, 8 of which were overdue.

7.115 The average time taken to close complaints (over the period from January 2021 to December 2024) is shown below:



7.116 By far the majority of complaints across both services, are received by maternity:



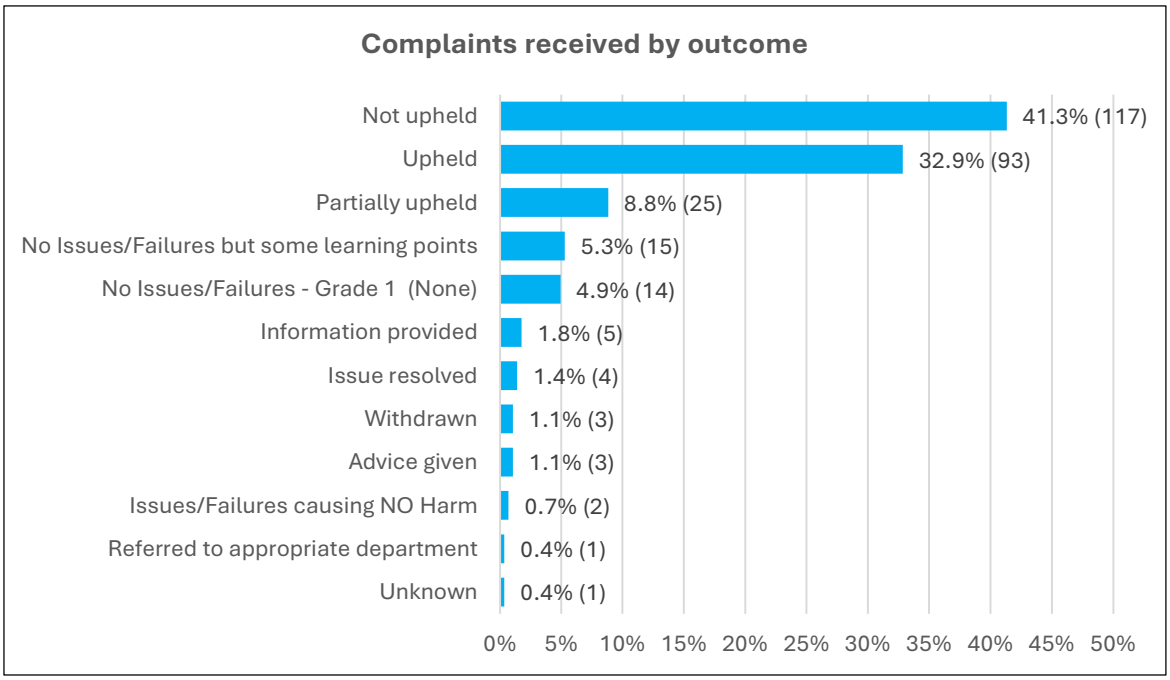
7.117 The improving trajectory of complaint management is in part illustrated by the fact that, towards the end of 2024, it was still not clear within the Health Board's governance structure exactly how many open complaints there were, whether they related to maternity, neonatal services, or both, and timelines for responding to women and families. Steps taken to improve the operational 'grip' of concerns and complaints in maternity include:

- Both the Clinical Director of Midwifery and the Service Group Associate Medical Director now sign off all complaint responses. Prior to September 2024, sign-off was only

undertaken by a Service Group Director which could cause delays; thus capacity and service-specific insight has improved.

- Concerns and complaints management is a key feature of Silver and Gold Command meetings, as well as being reported to Enhanced Monitoring Meetings.
- The capacity and capability for reviewing complaints and drafting clear, compassionate and tailored responses have increased and we saw evidence that the quality of responses is improving.

7.118 41.3% of complaints over the period were not upheld (the outcome most frequently recorded), with nearly a third (32.9%) upheld. For 5.3% of complaints, no issues were identified but there was some learning. The data supplied was collected by different systems at different points and there may be issues with consistency of recording as a result.



7.119 The number of complaints which are not upheld is concerning in maternity services. This could indicate that the objective assessment of the complaint might be flawed, biased, or being incorrectly recorded. When people complain, as identified in other areas of this report, they rarely ever make one complaint about an isolated issue, they more likely complain about an episode of care which has multiple factors (complaint categories) associated with it.

7.120 We would, therefore, expect to see significantly more numbers of partially upheld complaints in this dataset. It is important to use individual complaint allegations codes rather than make an assessment which has been 'rounded-up' across the whole complaint; this could equally look like denial and defensiveness.

7.121 Under the Putting Things Right guidance, Health Boards are encouraged to pursue early resolution of a concern within two working days. After this point, a concern converts to the formal process. There is currently no process to understand the volume and content of concerns raised and resolved within this timescale although we were told that early resolution of concerns should be reported via Datix. This prevents services having valuable insight into how effectively concerns are managed locally, and what the common characteristics are in these cases.

7.122 We understand that Putting Things Right guidance is soon to be updated, we strongly encourage that the findings of this review are incorporated into future versions.

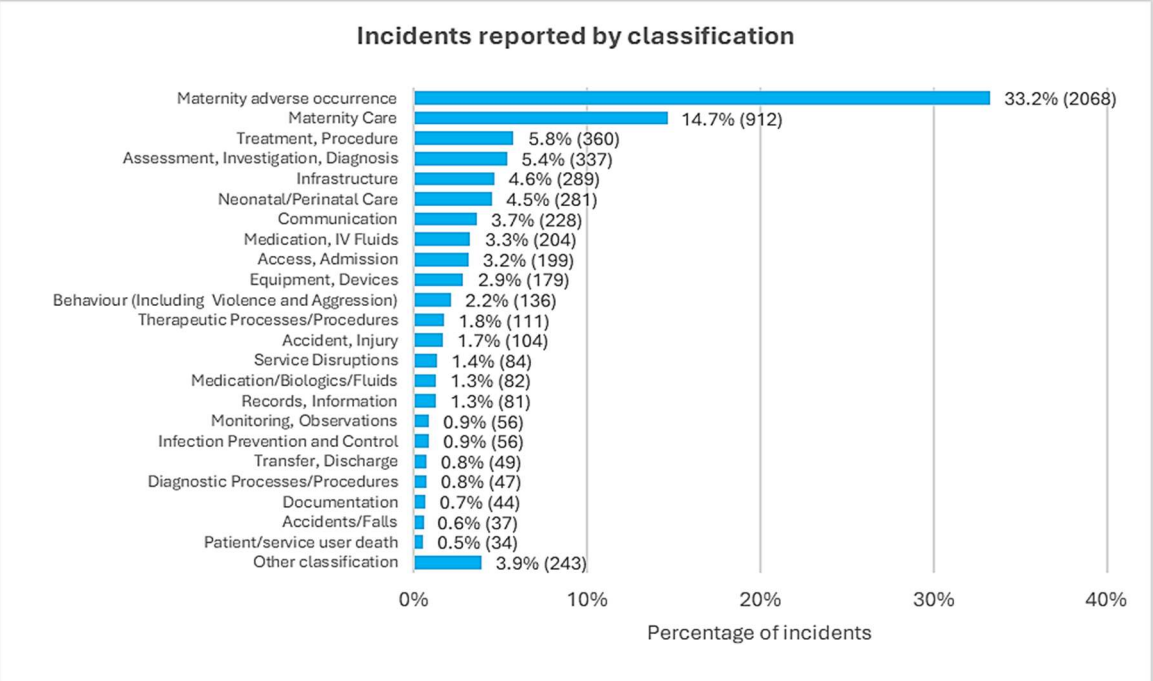
Responding to incidents

7.123 Our review of incidents has focused on understanding the effectiveness of incident reporting, investigation and subsequent learning in maternity and neonatal services. The importance of a culture in which staff feel that the proactive reporting of issues will be met with a supportive and learning-oriented response cannot be overstated.

7.124 In total there were 6,221 incidents reported between the 1 January 2021 and 31 December 2024, with an average of 130 incidents per month received over the period. The number of incidents reported over the period appears to be increasing, with the rolling 12-month average number increasing from 123 per month in December 2021 to 157 per month by December 2024.

7.125 A high incident reporting culture is usually seen as a positive indicator of safety. However, this particularly applies to incidents which are reported as low harm or 'near-miss' incidents. Incidents do not always indicate 'deficits' (issues) but a high number of serious incident reports could indicate a lot of deficits within the safety culture. It is very important that incidents are re-classified once investigation has occurred so that an objective appraisal of the event can be recorded; the Health Board does this.

7.126 The main classifications of incidents were as follows (over the period from January 2021 to December 2024):



7.127 To inform our understanding of incident management and to complement the findings arising from staff feedback and wider documentation review, we have undertaken a sample review of 10 incidents. We used an established assessment tool for this purpose.

7.128 The sample of incident investigations we reviewed highlighted several quality issues, as well as a lack of compassionate engagement of women and families in the process. We found:

- Some incidents scoring 'high' qualified for external independent review, although we saw little (but not zero) evidence of these having been commissioned as a matter of course.
- The depth of investigation was insufficient. In most cases, there was limited reference to the broader system in which the incident occurred. It was not possible, for example, to see that acuity on the day of the event had been considered, nor the staffing profile. The

advantages of adopting a systems-oriented approach to incident investigation are discussed in more detail below.

- Women and families were not engaged in the review. Even if an incident is low or no harm, it is good practice to involve women and seek their perspectives; this may highlight further opportunity for learning through the investigation process. The Health Board assesses incidents on both a subjective and objective basis of harm, however, we are unsure how this can be the case with little family involvement. This is particularly pronounced in maternity where the assessment of harm is almost universally rebased (post investigation) to a lower 'objective' level of harm by investigating staff.
- Timescales for closure were often indicative of a superficial review. Investigations were often completed within 24 hours of an incident being reported. We acknowledge in some circumstances this may be appropriate, but we also found examples of incidents being closed before the potential clinical outcome was known. For example, one case related to a delayed induction and the investigation was completed before the baby was born.
- The longest time it took to close an incident was 903 days. The average time it took to close an incident was 26 days and just over 55% were closed within 30 days of being opened.
- Documentation of the investigation process could be more thorough. This was particularly the case for low and no harm incidents. We found little information on Datix regarding whether feedback was provided to the patient or staff member involved and whether the investigation generated any learning.
- Incidents in our sample were not clearly triangulated with concerns raised or complaints, despite the same information being required in both reviews. Incident investigations did not use experiential feedback to better understand the impact on women and families or adequately share the learning across both incident and concern/complaint.
- A lack of multidisciplinary perspectives, particularly from the obstetric workforce.

7.129 Our review found that, during the period examined, the Health Board predominantly adopted a cause-and-effect approach to incident investigation, rather than a systems-based method. The latter emphasises that safety "arises from interactions, and not from a single component, such as the actions of people."[110]

7.130 The Yorkshire Contributory Factors Framework[111] is appended to investigation templates but rarely completed. The Framework is designed to help investigators map the potential factors underpinning an adverse event. The framework was introduced across all Health Boards as part of the 'Once for Wales'[112] reporting system which was launched in 2021. We heard, however, that the role of the framework was not emphasised nor has there been significant training on how to use it to best effect.

7.131 The Patient Safety Incident Response Framework[113] (PSIRF) recently adopted in England has sought to directly tackle this culture and to focus more upon issues of the 'system of care.' In particular, it seeks to understand repeated high numbers of reported incidents and how these can be understood in a more thematic way. The 'end user' error (the things that went wrong) is no longer considered as the primary causal factor and instead scrutiny is applied to the factors surrounding the 'event' (environment, staffing, training, acuity, equipment). Within this, examining human factors is vital – why the individuals responded in the way they did within that set of circumstances and was the work imagined the same as the work completed.

7.132 In understanding more of the issues associated with the 'system' there is more chance of making impactful and sustainable changes. PSIRF is very much premised on the notion that

human beings are imperfect, but they are also working within an imperfect system of care: most people who work in health and social care wish to provide the very best care they can, given the circumstances they are working in. There is very rarely an intent by staff to provide care that did not go as expected or planned and the many multiple other factors must be included in any conversations about harm[114].

7.133 We repeatedly heard calls from staff and external partners to the Health Board for a similar approach to be implemented in Wales. Notably, we also saw evidence of and heard about the efforts of individual members of neonatal staff to encourage a more system-based approach to reviewing adverse events by implementing changes and training themselves. A training package provided to some neonatal staff in October 2024, for example, included a summary of 'just culture' and its relevance to learning from incidents. It also covered the role of the Yorkshire Contributory Factors Framework in undertaking investigations. This is a positive development, although we understand this was largely service-led and there remains more for the Health Board, and wider NHS in Wales, to do to adopt a more sophisticated, system-based view of incident analysis.

Analysis of claims

7.134 Legal claims relating to avoidable harm in maternity services represent a significant proportion of clinical negligence claims in terms of value for the NHS in Wales. Legal and Risk Services (part of the NHS Shared Service Partnership in Wales) estimate that for 2023/24, almost 16% (105) of clinical negligence cases in Wales pertain to maternity services but make up over half (54.5%) of the costs to NHS Wales.

7.135 The Welsh Risk Pool, which is part of Legal and Risk Services provides the means by which NHS providers in Wales indemnify their organisations against risk and receive reimbursement, as members of the scheme, for the significant costs of litigation once claims have been settled. The Welsh Risk Pool also works with maternity and neonatal services in Wales to identify the themes from claims which have arisen.

7.136 SBUHB provided Datix extracts of maternity claims as follows:

- current open maternity claims at April 2023; and
- maternity claims made from 1 August 2023 to 31 August 2024.

7.137 We have provided some analysis of this data in the tables below. We do not provide detail of individual cases but provide a summarised analysis of the data which groups some claims into time periods to protect anonymity. The service location for the incident is as recorded on the Datix extract.

Open maternity claims – April 2023

7.138 Our review of the data showed that:

- There were 39 open claims at April 2023 (there were 40 on the Datix extract but one record appeared to be duplicated). Some of these claims have been ongoing for many years; the Datix record did not provide the date of the incident, so we are unable to assess when these incidents occurred.
- 32 claims related to Singleton Hospital maternity unit and were opened over the period from late 2018 to April 2023
- Seven claims related to Neath Port Talbot Birth Centre; five of these were opened in early 2021 and two were opened in mid-2022.
- For claims relating to the maternity and neonatal units at Singleton Hospital, 15 related to incidents occurring on labour ward/delivery suite, 10 in obstetric theatres, 6 related to

antenatal care and one related to NICU. We note that we have not been able to validate the data on location to which these claims relate but have taken the Datix as an accurate record; there were some instances where it appeared that the location stated may be inaccurate given the nature of the claim.

Year	No. of claims opened	Service location (no. of incidents)	Summary of allegations
2018-2020	3	Obstetric theatre (2) Antenatal ward (1)	Care during labour and delivery Omission in care and brain injury to baby Monitoring/observations and brain injury to baby
2021	23	Labour ward/delivery suite (8) Obstetric theatre (7) Antenatal ward/clinic (2) NICU (1) Neath Port Talbot Birth Centre (5)	Omission in care and brain injury to baby Medication issue Assessment/CTG monitoring Birth injury to baby – instrumental delivery, birth complications (shoulder dystocia) Delayed escalation to obstetrics, neonatal team Omission in care (stillbirth) Management of hypertension Access to NICU Information and advice, including place of birth, brain injury Epidural issue Treatment following caesarean section Management of delivery and post delivery
2022	10	Labour ward/delivery suite (5) Antenatal ward/clinic (2) Obstetric theatre (1) Antenatal Clinic/Neath Port Talbot Birth Centre (1) Neath Port Talbot Birth Centre (1)	Birth complications Delay leading to HIE Omission in care leading to stillbirth Timing of induction of labour Omission in care following delivery Assessment and monitoring Omission in care leading to trauma Omissions in care and treatment Omission in antenatal care, birth defect
2023	3	Labour ward/delivery suite (2) Antenatal assessment unit (1)	Omission in care leading to stillbirth Induction and delayed transfer to labour ward Management of pregnancy/delivery

Maternity claims – 1 August 2023 to 31 August 2024

7.139 There were 12 maternity claims made over the period, one of which was withdrawn. The following table summarises these claims, including the approximate date of the incident which was provided in this Datix extract. Three of these related to incidents which had occurred over the period from 2009 to 2011, illustrating the often-extended elapsed time before a claim is made.

7.140 The analysis shows that for these most recent claims over half (seven) related to care on labour ward/delivery suite, two related to obstetric theatre and three related to antenatal care. However, we noted that location of the incident did not reflect the summary description in some cases.

Year of incident	No. of claims opened 23/24	Service location (no. of incidents)	Summary of allegations
2009-2011	3	Labour ward/delivery suite (2) Obstetric theatre (1)	Injury from traumatic delivery Management of pregnancy/delivery Omission in care leading to birth injury
2018-2019	2	Antenatal ward (2)	Trauma due to birth experience Management of pregnancy/delivery
2020-2021	3	Labour ward/delivery suite (3)	Birth injury, stillbirth Assessment and monitoring
2022-2023	4	Labour ward/delivery suite (2) Obstetric theatre (1) Antenatal ward (1)	Omissions in antenatal and postnatal care Mismanagement of labour and delivery Omission in care post-delivery Inappropriate treatment

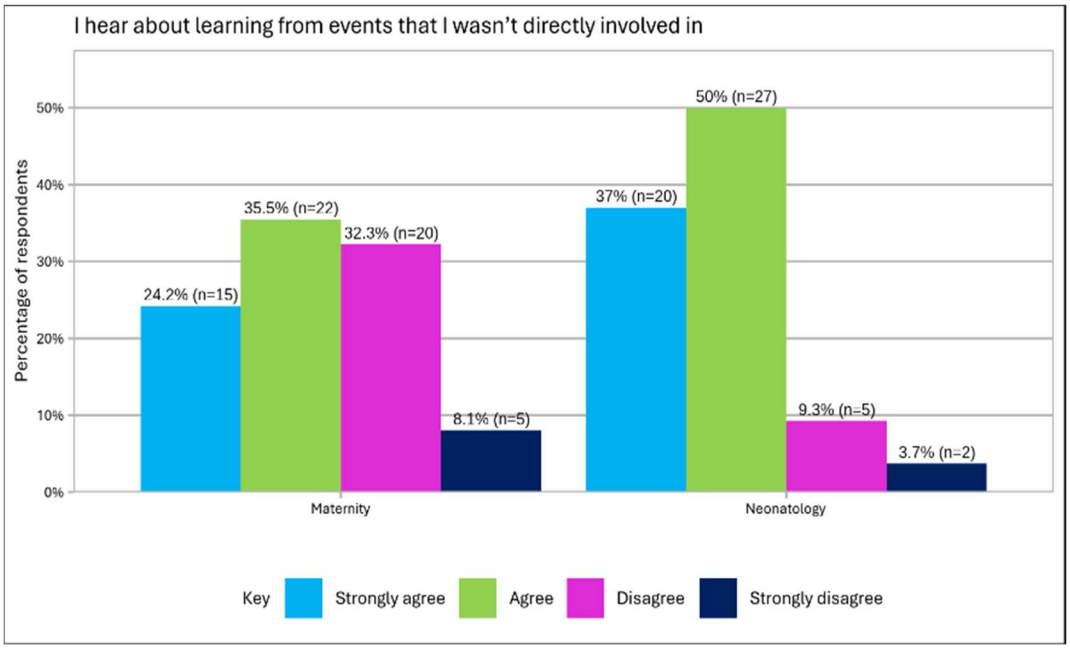
7.141 The Datix extract had limited descriptive detail on the nature of the incidents, but it showed that birth injuries (including HIE) feature strongly in the themes of claims; in addition, traumatic birth experiences are prominent in the themes emerging.

7.142 Our review of complaints and incident management (see above) has identified issues in terms of the quality of responses to women and families, a lack of compassion and limited involvement in investigation processes; this creates the risk of further escalation. Incidents, complaints and claims are reviewed by the Health Board in isolation, and we did not see a systematic approach to triangulation. Understanding the links between incidents, complaints and claims is critical to gaining the level of insight required to understand why a claim has arisen and how this could have been avoided.

Mechanisms to share learning

7.143 Collating and communicating learning and improvement is a key component of a mature safety culture. Ensuring that staff are not only aware of but actively engaged in improvement from incidents and concerns/complaints has a reinforcing effect; staff feel more compelled to report issues because they know that there is value in doing so.

7.144 Throughout our interactions with maternity staff, a consistent concern raised was the lack of effective mechanisms for sharing learning (see graph below). This feedback is notable, particularly when viewed alongside the broadly positive signals about psychological safety and willingness to report when things go wrong. The need to strengthen feedback loops to staff, particularly in relation to learning, was also highlighted by the HIW.



7.145 During our review, staff began to speak more positively about the range of mechanisms used to share learning and it was evident that learning processes were becoming more embedded. For example, learning themes have been included in recent teaching sessions, shared in daily safety huddles, and are receiving increasingly more focus in service-level governance forums.

7.146 Useful work has been undertaken in this area. For example, many staff told us about 'Risky Business,' a quarterly newsletter introduced in 2024, which contains learning from incidents, concerns and complaints, audit practice and mortality. We saw examples of hard copies available to staff during our site visits and noted that there is also a QR code which allows staff to share feedback on the newsletter. There was a high degree of positivity about this approach and several people praised the governance team's efforts to elevate the profile of learning.

Quality oversight framework

7.147 The following section deals with the services' approach to ensuring that they integrate current best practice principles and are proactive in response to safety intelligence. We have considered:

- How the service responds to national policy, such as the Maternity Neonatal Safety Support Programme Cymru[115].
- The governance of clinical guidelines.
- The connectivity between safety intelligence, such as its incident profile, and quality improvement.
- The effectiveness of clinical audit.

National policy

7.148 The Maternity and Neonatal Safety Support Programme (MatNeo SSP) in Wales was launched in 2022 to improve safety, quality and experience for women, babies and families and ensure a more consistent approach across maternity and neonatal care. The programme is supported by Improvement Cymru and aims to foster a culture of continuous improvement across Wales.

7.149 Since early 2024, MatNeo SSP work at SBUHB had concentrated on recommendations published after the 'discovery phase' of the programme concluded in February 2023. This phase involved collaboration with staff from services across the country and produced a prioritised action plan for Health Boards to implement which was structured around the programme's key objectives of:

- skilled multi-professional teams;
- family-centred care and continuity of carer;
- safe and effective care; and
- sustainable quality services.

7.150 Overseen by the Maternity Improvement and Assurance Board, the Health Board has developed a comprehensive action plan to bring services to the standard set out in the discovery phase report. Each service has a MatNeo SSP champion who is responsible for the local monitoring of progress against the overall action plan. We were told that the maternity champion is currently on long-term leave. Given the importance of this work, and scale of the work required by the discovery phase report, action is required in this area to ensure that progress is not undermined.

7.151 The Quality Statement for Maternity and Neonatal Services in Wales was also published in February 2025, and builds on the findings and recommendations with the MatNeo SSP. This high-level document outlines the government's vision for services and seeks to set expectations for each Health Board to meet. We were told that over the next 12-24 months, the National Strategic Clinical Network for Maternity and Neonatal Services (the network) will develop a set of detailed service specifications which will include measurable outcomes. The longer-term vision is that this will provide a framework against which systematic reporting, including benchmarking, can be structured.

7.152 In response to the Quality Statement, all Health Boards in Wales are required to undertake a baseline review. We have been told that this work is underway, but we can also see strong correlation between the detail of the Quality Statement and the MatNeo SSP action planning work, which is reasonably developed. The network has also established a MatNeo SSP Oversight Group which we understand is due to start meeting imminently and will seek to support Health Boards to collaborate and share learning as they implement the MatNeo SSP actions, as well as identify areas in which coordinated, Wales-wide support and intervention is needed.

7.153 All Health Boards are required to implement the Perinatal Engagement Framework which was published at the same time as the Quality Statement. Several senior staff we spoke to welcome the national focus in areas such as engaging with seldom-heard groups, strengthening collaboration with women and families and promoting a culture in which all feedback is valued, heard and acted upon. There was also acknowledgement from staff that there was significant work to do to align to this framework.

Clinical guidelines

7.154 Clinical guidelines are managed locally by the maternity governance team and once complete, are uploaded to the Wales Information System for the Dissemination of Obstetric Gynaecology and Midwifery Material web page.[116]

7.155 170+ guidelines, standard operating procedures or algorithms are currently in operation and require good governance processes to manage the review and update as they reach their expiry date, usually every three years. We found there was a lack of defined and well-embedded process to manage clinical guidelines. We strongly urge the service to redesign its approach to ensuring guidelines are in date, including proactively tracking guidelines which may be due to expire, and ensuring that all guidelines have a multidisciplinary review prior to sign off.

Quality improvement

7.156 The Health Board's corporate approach to quality improvement lacked clear direction, structure and consistency until the last 12-24 months. A five-year quality strategy was developed for 2023-2028, which reflects the Health Board's Duty of Quality[117] to "achieve a system-wide approach to quality that leads to improvement in the way we work; and to include quality in all the decisions we make."[118] The publication of the strategy was a positive first step towards achieving this. It is, however, notable that the strategy makes no reference to the Health Board's preferred improvement method, which we were told is a "model for improvement."

7.157 We heard that there was limited corporate support for service-level staff to design, implement and monitor quality improvement initiatives. As set out in section 6, the capacity of many managers is already constrained by staffing pressures and the frequent need to divert to support clinical colleagues. Ward managers felt that there was much more they could do to progress planned areas of quality improvement if they had more capacity.

7.158 Throughout our work, we heard about the extensive quality improvement work that is undertaken within neonatal services. Almost every member of staff we spoke to from the team was able to tell us about recent projects and the impact they have had on care delivery. It was evident from staff feedback and site visits that there is an encouraging and supportive culture that, where capacity allows, enables staff from all professions to participate in improvement work.

7.159 Since early 2024, we have seen encouraging signs that the quality improvement approach in maternity care is gaining momentum. Whilst up to early 2024, it was largely reactive, low-profile and driven by a small group of individuals, it is now becoming more coherent, visible, and structured. We saw plans to further develop this approach throughout 2025 and ensure that there is stronger alignment between the service's response to areas of weakness and, wherever possible the quality improvement approach. The planned quality improvement initiative on themes in concerns/complaints is an example of this. This approach has the potential to significantly improve the extent to which the service can evidence and evaluate the impact of changes to practice it has made in response to learning from safety intelligence, such as experience data, external review findings and themes and trends in adverse events.

7.160 Staff told us that perinatal quality improvement projects, notably Perinatal Excellence to Reduce Injury in Premature Birth (PeriPrem) Cymru, have been a valuable opportunity to collaborate, learn from each other's insights, and begin to develop an approach to quality improvement that is consistent across the perinatal pathway.

Case study – Perinatal Excellence to Reduce Injury in Premature Birth (PeriPrem) Cymru

Born from a national quality improvement programme launched to improve the outcomes from preterm babies in Wales, this centres on a care bundle of 11 interventions that span antenatal, intrapartum and neonatal care:

1. Antenatal steroids to accelerate fetal lung development
2. Magnesium sulphate for neuroprotection of the fetus
3. Delayed cord clamping
4. Optimal thermal care
5. Use of breast milk
6. Minimising early separation
7. Use of probiotics, early caffeine, and appropriate oxygen targets.
8. Team communication and parental involvement
9. Timely respiratory support
10. Reduction in unnecessary intubation and ventilation
11. Data collection and real-time feedback to support continuous learning

SBUHB's work on elements of the perinatal care bundle has been ongoing for several years but became a more structured and formalised collaboration with the establishment of a dedicated Perinatal Quality Improvement Group in late 2022. This initiative has since matured into a robust governance framework, characterised by strong cross-service leadership through appointed clinical champions, early warning 'red flags' to flag non-compliance, comprehensive outcome analysis, and benchmarking informed by intelligence from the National Neonatal Audit Programme (NNAP) and Vermont Oxford Network (VON).

The Health Board has received national recognition as the leading perinatal service in Wales for delivering all key interventions based on 2023–2024 data. Notably, SBUHB now leads the country in the use of early breast milk, a significant milestone in neonatal care. It has also served as the national 'proof-of-concept' site for antenatal corticosteroid use, establishing itself as the foremost tertiary unit for this intervention in Wales. These achievements have been made possible by a consistent multidisciplinary approach, such as targeted diagnostic training for obstetric staff and the coordinated oversight of the programme as a whole.

Clinical audit

7.161 We saw many examples of high-quality reports summarising the outcomes of individual audits. Services can demonstrate active involvement in the national audit programmes, such as the UK Obstetric Surveillance System[119], National Neonatal Audit Programme[120] and Vermont Oxford Network (VON)[121], as well as in the subsequent sharing of learning, for example, the Health Board benchmarks favourably in VON data in relation to temperature control prior to admission.

7.162 The overall governance of clinical audit has, however, been weak in both services for several years. As a core part of an effective quality oversight framework, we would expect to see a service-level clinical audit plan which is agreed before the start of the financial year, and structured according to national requirements, organisational priorities and locally identified quality improvement initiatives. Instead, we heard that clinical audit is driven by areas of quality improvement activity.

7.163 We were not provided with clinical audit plans for either service for the years 2020-2024. A draft clinical audit plan for 2025/6 was shared with us, but this requires further development. The Health Board advised that a final version was approved in May 2025. The draft version we have seen contains no planned start dates and local audits are not aligned to the key areas of improvement work underway in services. There is currently a pressing need to ensure that there is local 'grip' of service-level audit activity to identify timescale slippage, reallocate audits when individuals are unable to lead key pieces of work, and to be able to provide holistic assurance on progress against the plan.

7.164 There should be clear links between the service's identified areas of recurring weakness, such as that identified via thematic analysis of incidents and the steps taken to address these areas. Plans should list the timescale for audits, who is responsible for the audit and where outcomes will be reported and monitored. There should also be a clear reporting and assurance framework for clinical audit that ultimately provides the Board with assurance that clinical audit is effective.

7.165 The approach to clinical audit would benefit from a more multidisciplinary approach. We noted that there is currently no audit midwife in post and repeatedly heard calls for an expansion of capacity in this area.

7.166 Work is currently underway to implement AMaT (audit management and tracking), a digital platform which captures and monitors clinical audit and quality improvement processes. Several people told us that the implementation of AMaT will significantly enhance governance, providing a management tool for staff involved in audit and providing greater visibility and assurance reporting within the Health Board's governance structure.

7.167 The Health Board has a Clinical Outcomes and Effectiveness Group which is a subgroup of the Quality and Safety Committee. This group is tasked with oversight of clinical audit programmes and outcomes. Documentation provided revealed several weaknesses in the overall approach to clinical audit and its application to maternity and neonatal services, namely:

- A highly retrospective work programme; for example, audit plans for 2022/3 and 2023/4 were considered at the March 2025 meeting. This significantly undermines the extent to which the Health Board can be confident about clinical audit processes in place today.
- Little focus on locally determined clinical audits, the focus being on national clinical audits. Local audits are key to a sound quality oversight framework.
- Weaknesses in intelligence about clinical audit management, for example, how often were target dates revised and how many staff were involved in audits.
- There was no evidence that clinical audit outcomes are considered as potential risks for inclusion in service level risk registers.

7.168 We understand that the Quality and Safety Committee is considering how its oversight of clinical audit could be improved. It has been proposed that Service Groups provide an overview of clinical activity to the Clinical Outcomes and Effectiveness Group. We suggest that the above findings are incorporated into the ongoing discussions in this area.

ATAIN

7.169 ATAIN (Avoiding Term Admissions into Neonatal Units) is a programme of work to reduce harm that leads to term admissions; the emphasis of this initiative is to avoid unnecessary separation of mother and baby. Incidents of term babies being admitted to NICU are reported on Datix by maternity staff and a rapid review is undertaken by governance midwives within 72 hours to identify any 'make-safe' actions.

7.170 ATAIN reviews are designed to be multidisciplinary, but this frequently does not happen, due to constrained capacity. Whilst there is a dedicated ATAIN team in place, with staff from both maternity and neonatal teams, and weekly meetings scheduled to bring the team together, it is not uncommon for cases to be reviewed from a maternity perspective, followed by a separate neonatal-led review. Obstetric input was repeatedly highlighted as a problem; we have explored capacity constraints in this area in more detail in section 6. There was broad acknowledgement from interviewees that this is suboptimal, and we heard that leaders in both services are looking at ways in which ATAIN reviews, as well as broader reviews of mortality and morbidity, can be undertaken together.

7.171 The focus in this area should be prioritised. Without a consistent multidisciplinary review of ATAIN cases, there are limitations to the quality of learning and improvement that service can make.

7.172 There is a backlog of ATAIN cases from 2024; additional ATAIN meetings are currently taking place to reduce this backlog. There has been an upwards trend in ATAIN cases since 2022; several people we spoke to attributed this to the increase in caesarean section rates since the Royal College of Obstetrics and Gynaecologists changed guidance associated with planned caesarean birth[122], and the associated higher risk of babies suffering with respiratory complications.

7.173 ATAIN reviews are improving, and greater intelligence is now provided to forums such as the Quality and Safety Group. It is clear to see how the Health Board benchmarks against peers and how analysis leads to resultant actions. There is, though, a need to define how overall progress against actions in both services will be monitored in the newly proposed perinatal governance structure referenced earlier in this section. We also saw little evidence of a systematic approach to sharing learning with staff following ATAIN reviews and some staff acknowledged that this is an area of weakness. It was not clear how learning from ATAIN is shared with staff and translated into changes in practice, for example, changes required to guidelines associated with the monitoring of cord gases in newborns.

Perinatal Mortality Review Tool (PMRT)

7.174 All stillbirths (for babies who died in pregnancy from 22 weeks' gestation) and neonatal deaths are subject to review using the Perinatal Mortality Review Tool (PMRT)[123]. This is a structured approach to local reviews of care when babies die and is designed to provide answers for bereaved parents about the care they received and to ensure local learning to drive improvement. The effective use of the PMRT relies on a strong multidisciplinary approach although this has not always been evident due to limited obstetric capacity.

7.175 Additionally, it is good practice to have an independent panel member in mortality review meetings to inject additional assurance and challenge into the process.

7.176 Through the PMRT process which is aligned to the Each Baby Counts[124] criteria, cases are graded from A (which indicates that there were no care issues identified), to D (which indicates that there were care issues identified which definitely affected the outcome). The network will assess and challenge the grades applied by the Health Board; in most cases, the network corroborated the grading given or suggested the application of a lower grading.

7.177 Thematic analysis of 2023 cases (2024 cases are not yet complete) identified that improvements were needed in relation to CTG monitoring before and during labour, and in the identification of sepsis. We found, however, that the reporting of such learning and triangulation with other forms of safety intelligence were lacking, and this has been set out in more detail earlier in this section. CTG, for example, was also a concern raised by the HIW in 2024 and forms part of the associated action plan.

7.178 Since 2020, and largely due to the Covid-19 pandemic, there have been significant delays in placental pathology and postmortem results. This remains a current concern, and we understand that the implications of this on the timeliness of PMRT reviews has been escalated to the network, as it is a Wales-wide issue. Several staff spoke of the additional trauma that this delay causes to bereaved parents. The Health Board is seeking to mitigate this by ensuring all families receive a letter explaining the possible delays although the root cause issue requires additional resource which is outside of the immediate control of the Health Board.

7.179 Detailed analysis of MBRRACE-UK data is included in section 3 and we have set out our findings in relation to the need to strengthen the oversight of mortality and associated learning earlier in this section.

Focus on HIE (Hypoxic-ischaemic encephalopathy)

In its report of September 2022, the Evolution of the Early Notification Scheme, NHS Resolution highlights that **"Each case represents a real family now caring for a child with potentially complex needs. These families will feel the impact of the injury in different ways, at different times."**[125]

Hypoxic Ischaemic Encephalopathy (HIE) HIE is a term doctors use to refer to a brain injury caused by not enough oxygen reaching a baby's brain when it is being born It can also be referred to as intrapartum asphyxia. Premature babies are at higher risk of HIE and that is why close and careful monitoring and management of risk in pregnancy is needed.

Treatment for HIE has improved using therapeutic cooling. This involves taking a baby as soon as possible after birth (but in any event usually within six hours of birth) and putting them in a controlled environment which will bring their body temperature down for about 72 hours before a gradual rewarming process is started. This process has been shown to reduce the risk of serious brain injury.

However, there are cases where a baby still suffers a hypoxic brain injury and cooling does not work, is not considered, or is not instigated quickly enough. These cases might indicate harm and require investigation, particularly when the baby was born at 37 weeks gestation or beyond and within the first seven days following their birth they:

- were diagnosed with a moderate to severe HIE, and/or
- were actively therapeutically cooled and is still showing signs of neurological injury, and/or
- had an altered state of consciousness with seizures, weak muscle tone, abnormal reflexes or abnormal suck.

Research by the Early Notification Scheme in England indicate that problems with fetal monitoring during pregnancy and birth were identified as a factor in 70% of all cases. A further significant cause relates to complications that can arise with positioning of the baby at caesarean section (specifically when the fetal head becomes impacted in a woman's pelvis).

When a baby suffers serious brain injury this can have a profound and unimaginable impact upon the baby, their family, brothers and sisters and on family life. A baby and child with severe brain injury may require 24-hour care. This completely changes the course of life for those parents who, in looking after their own child, then must be forced to face financial challenges, fears for the future, their own stress and management of the psychological impact. This is often directly following the impact of enduring or witnessing a traumatic birth.

Traditional claims processes are long, and families have often faced years of financial uncertainty and struggle, having to 'prove' themselves and deal with an often-adversarial process. This is what the ENS has tried to tackle directly and there is a significant requirement for the same principles to be adopted in Wales. Family centred approaches should now be mandatory.

In 2023 and early 2024, there was a significant spike in HIE cases. The Health Board have attributed this to staffing, which is evidenced (2023 saw the highest rates of shifts which were not sufficiently staffed), however, we also found that in 2023:

- There was a spike in births during May (particularly at Singleton Hospital).
- In the second half of 2023, more mothers gave birth who were over the age of 30.
- In 2023, the average length of stay in the maternity unit spiked and there were significantly more caesareans (at 6% this was the highest point in 5 years).
- Induction rates saw some of the largest fluctuations between months although overall the number of inductions was lower for that year.
- There was a steady increase in low birthweight babies (although a reduction is SGA babies).
- There was an increase in babies transferred to NICU.
- In mid -late 2023, there was a significant spike for bed occupancy in triage.
- In late 2023, over 5% of babies had a low Apgar score at birth.
- Continuity of care rates were substantially variable during 2023 but were on an overall downward trajectory.
- Neonatal unit deaths (after 28 days) spiked significantly in 2023.

The HIE rates in 2023 may therefore be indicative of a combination of:

- an unanticipated surge in attendances with insufficient staffing, particularly in triage, with lower continuity of care rates; staffing was also very inconsistent across the year. Women may have had difficulty accessing a bed;
- more caesarean sections which could indicate more emergency births (although we cannot correlate 'choice' in this number), caesareans are associated with higher numbers of HIE;
- babies who were born in a poorer condition overall with a potentially worse prognosis upon entering NICU.

Historically, monitoring of HIE has been a weakness in terms of governance at the Health Board and the detailed analysis and learning has lacked both sophistication and translation into practice. Newer reports created by the Health Board recognise the need to monitor HIE performance against national benchmarks on the maternity and neonatal dashboard to provide assurance at departmental, service group and corporate level.

7.180 Since 2022, quarterly HIE Morbidity meetings have been held at a network level with engagement from midwives and neonatal consultants. In line with wider findings in this section, we note that there is not currently an obstetric lead assigned to HIE.

7.181 Review of HIE Morbidity meetings shows meetings centre on the presentation of individual cases using a template provided by the network. We understand that the templates are completed by one midwife, rather than resulting from a multidisciplinary review of the case.

Cases are graded by staff working within the service and uses the Each Baby Counts[126] criteria. Minutes document detailed discussion on each case and the extraction of possible learning points. Overall, however, we found a lack of thematic analysis or identification of recurring issues. Network meetings do not monitor and benchmark cases either and therefore it is not clear how services are monitoring whether they are an outlier in this area.

7.182 During our fieldwork, we noted that the All Wales Incident Trigger List did not include cases involving babies undergoing therapeutic hypothermia (cooling), a recognised intervention following HIE events. The omission of such cases limits the organisation's ability to gain comprehensive insight into its HIE profile. Our review of OCRIM meeting minutes from 2021 onward did not indicate the existence of a systematic process for reviewing babies who receive active cooling. However, it is encouraging to note that the Enhanced Monitoring Performance Pack for May 2025 confirms the inclusion of cooling as a new trigger for case presentation at OCRIM. This represents a positive step towards improving oversight and learning in this critical area of care.

7.183 Several staff also shared the view that the All Wales Incident Trigger List could be better tailored to maternity and neonatal services. For example, Category 1 lower segment caesarean section is not included, therefore an investigation of incidents of related emergencies is not triggered.

7.184 More recently, SBUHB has undertaken a comprehensive review of HIE cases. The report, Oversight of quality and outcomes of moderate to severe HIE at SBUHB, sets out their current approach to the review and oversight of HIE cases with detail on those which occurred in 2023/24. All HIE cases are reviewed by the perinatal team (obstetric and neonatal teams) who provide a named point of contact for the family and offer engagement with the clinical review through a face-to-face meeting when a statutory Duty of Candour conversation is held. All families receive written confirmation of the review process and are invited to engage and submit questions for inclusion in the review. All families are offered a meeting to discuss the outcome of the review. This process was undertaken for all cases in 2023/24. The report identifies the learning themes from the cases and provides a summary of actions taken/in progress for both maternity and neonatal teams.

7.185 The report provides useful benchmarking analysis on moderate to severe HIE rates using data from the National Neonatal Research Database. Benchmarks are not available nationally to compare rates of moderate to severe HIE so SBUHB have taken positive steps to look at alternative sources of data.

7.186 This is a useful and detailed report; however, historically monitoring of HIE has been a weakness in terms of governance. The report recognises the need to monitor HIE performance against national benchmarks on the maternity and neonatal dashboard to provide assurance at departmental, service group and corporate level.

8. Next steps

8.1 The Health Board has made a commitment to continue this conversation to ensure that any women and families who missed the review, or felt unable to participate, are still able to provide their stories. Particularly:

- The self-referral website will now transfer to the Health Board from the Niche landing-site.
- The review triage midwife will remain in her support role over the next few months.
- More recently families have been supported to meet with very senior leaders within the Health Board so that they are able to provide a first-hand account of their experiences.
- The psychological support put in place through the course of this review, will remain open for the foreseeable future.

8.2 The Terms of Reference state that following completion of the Review, the Oversight Panel will continue to oversee the implementation of any recommendations against key milestones.

8.3 Therefore, after publication of the report, the Oversight Panel's focus will turn to:

- supporting the engagement of service users and key stakeholders to facilitate a partnership / collaborative approach with the Health Board in developing the improvement plan;
- quality assuring the improvement plan produced in response to the recommendations to ensure the actions will timely address the recommendations; and
- undertake a periodic review, at six monthly intervals, against key milestones and reporting the Board of the Health Board.

8.4 In September 2026, the Oversight Panel will consider the progress made against the milestones and whether, at that point, the Oversight Panel will formally end their input to the Health Board.

8.5 The Oversight Panel are pleased to submit this review to support further learning across Wales and across England. The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board would be particularly happy to support the development of standardised Terms of Reference for maternity reviews which consider to full and extensive volume of facts relating to the performance of maternity and neonatal services.

Final acknowledgements

We would like to thank all participating families, communities, staff, stakeholders and the Health Board for their positive contributions to this review. We hope that the extensive work detailed in these pages is helpful towards the continued improvements in maternity and neonatal services at Swansea Bay University Health Board and across Wales.

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