



**Swansea Bay University Health Board (SBUHB)
Minutes of the Special Board Meeting
held on 15 July 2025 at 11:30pm**

| Present: | | |
|-----------------------|-------|--|
| Jan Williams | (JW) | Chair |
| Stephen Spill | (SS) | Vice Chair |
| Abigail Harris | (AH) | Chief Executive Officer |
| Richard Evans | (RE) | Executive Medical Director & Deputy Chief Executive |
| Jean Church | (JC) | Independent Member |
| Jackie Davies | (JD) | Independent Member |
| Marie Davies | (MD) | Executive Director of Planning and Partnerships |
| Deb Lewis | (DL) | Chief Operating Officer/Executive Director of Primary Care & Community and Mental Health & Learning Disabilities |
| Anne-Louise Ferguson | (ALF) | Independent Member |
| Andrew Griffiths | (AG) | Independent Member |
| Darren Griffiths | (DG) | Executive Director of Finance and Performance |
| Matthew John | (MJ) | Director of Digital |
| Nicola Matthews | (NM) | Independent Member |
| Christine Morrell | (CM) | Executive Director of Allied Health Professions and Health Science |
| Reena Owen | (RO) | Independent Member |
| Patricia Price | (PP) | Independent Member |
| Gill Richardson | (GR) | Assistant Director of Policy, Research and International Development |
| Tina Ricketts | (TR) | Executive Director of Workforce & OD |
| Liz Rix | (LR) | Executive Director of Nursing and Patient Experience |
| Nuria Zolle | (NZ) | Independent Member (via Teams) |
| In Attendance: | | |
| Denise Chaffer | (DC) | Oversight Panel Chair |
| Amelia Cole | (AC) | Corporate Governance Coordinator |
| Sarah Collier | (SC) | Head of Psychology |
| Karen Frazer | (KF) | Ty Ellis |
| Sophie Herbert | (SH) | Corporate Governance Coordinator |
| Hazel Lloyd | (HL) | Director of Corporate Governance |
| Osian Lloyd | (OL) | Head of Internal Audit |
| Ken Sutton | (KS) | Oversight Panel Member |
| Claire Taylor | (CT) | Llais |
| Richard Thomas | (RT) | Director of Insight, Communications and Engagement |



Apologies:

| | | |
|-------------|------|--------------------|
| Keith Lloyd | (KL) | Independent Member |
|-------------|------|--------------------|

Acronyms

| | | | |
|-------|-------------------------------------|-------|--|
| SBUHB | Swansea Bay University Health Board | DoI | Declarations of Interest |
| WG | Welsh Government | AC | Audit Committee |
| AW | Audit Wales | IMTP | Integrated Medium Term Plan |
| AGM | Annual General Meeting | RPB | Regional Partnership Board |
| CHC | Continuing NHS Healthcare | WODC | Workforce and Organisational Development Committee |
| HDUHB | Hywel Dda University Health Board | CMHT | Community Mental Health Teams |
| LA | Local Authority | MH | Mental Health |
| LD | Learning Disabilities | DDRIC | Digital, Data, Research and Innovation Committee |
| QSC | Quality and Safety Committee | | |

The meeting began at 11:14.

| Minute Ref: | Agenda Item |
|------------------------------------|---|
| PART 1: PRELIMINARY MATTERS | |
| 1.1 WELCOME AND APOLOGIES | |
| 112/25 | <p>JW opened the meeting by extending a warm welcome to all, and particularly to DC and KS from the Oversight Panel of the Maternity and Neonatal External Review. She also welcomed MH and CT from Llais, and members of the public present.</p> <p>JW confirmed the intention to record the meeting; although it was not a formal public meeting, she advised that the Board would take questions at the end of the meeting, with the exception of questions about any individual member of staff or patient, or any ongoing clinical negligence cases.</p> <p>JW went on to summarise the role of the Board as the Governing Body of the organisation, forming the highest level of decision making. The Board had a bi-monthly programme of scheduled meetings; however, there were times when a matter was of such importance that the</p> |



Board had to convene a special meeting, as was the case today. The Board had convened to receive the final report of the *Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board* (SBUHB).

JW warned that the report contained information relating to having a baby; some of the content could be distressing, particularly for those who had experienced pregnancy complications, infant loss or related trauma. She asked people to take care when reading the report and referred to the support available, should that be necessary.

JW outlined the events that had led up to the Independent Review(IR); the Board had commissioned it in December 2023 following: (i) a critical report received from Healthcare Inspectorate Wales (HIW) based on an unannounced visit to SBUHB maternity services in September 2023, and (ii) a number of serious concerns raised by women and families about their experiences. The Board had previously acknowledged, and apologised for, the length of time taken to fully establish the IR and JW reiterated that apology.

Over 1000 people had responded to the IR; JW extended her thanks to them all for their preparedness to relive traumatic experiences and share details of the poor care they had received. JW recognised and fully respected the decisions made by some families not to engage with the IR and assured them that their voices and experiences were as important as the voices of those who had engaged. SBUHB had received the Family Led Review (FLR) on 14 July and, on behalf of the Board, JW welcomed it as another significant contribution to inform the Improvement Plan. The Board would now take the time to study carefully the recommendations set out in the FLR as they related to SBUHB; JW would liaise with Welsh Government to confirm the arrangements for considering those recommendations relating to national bodies.

Action: JW

JW was conscious that the meeting and IR report publication coincided with Birth Trauma Awareness Week, a time of heightened sensitivity; the Birth Trauma Association was aware of the intention to hold the meeting and recognised that it represented another opportunity for women and families to voice their experiences.

JW recognised that the IR report made for hard and difficult reading and, on behalf of the Board, apologised wholeheartedly and unreservedly for the failures described. Services had fallen well below the standards expected and JW was truly sorry for letting down those women and families whose experiences had been so poor. She also apologised for not listening and committed the Board to doing so



| | |
|--|---|
| | conscientiously from now on, as part of helping the services to be the best that they could be. |
|--|---|

1.2 DECLARATION OF INTERESTS

| | |
|--------|--|
| 113/25 | There were no declarations outside those already on the Declarations of Interest Register. |
|--------|--|

PART 2: MAIN AGENDA

2.1 MATERNITY AND NEONATAL EXTERNAL REVIEW REPORT

| | |
|--------|---|
| 114/25 | <p>JW welcomed DC and KS, extending the Board’s grateful thanks to them and all members of the IR team for the robust, objective and independent scrutiny that underpinned the report and for the ‘blueprint’ it offered to develop excellent services, through learning and improvement.</p> <p>DC thanked JW and made some introductory remarks: the report summarised the experiences of over 1000 women and families, and DC thanked them all again for their preparedness to relive distressing and traumatic times. They had done so in the expectation that SBUHB would learn from them and take immediate and sustainable action to improve services.</p> <p>Using a slide presentation, DC summarised the background to the commissioning of the report: the HIW report; MBRRACE reports; and the significant concerns raised by families.</p> <p>The report comprised five components:</p> <ul style="list-style-type: none"> • The voices of families, reported in a raw form, which came through loud and clear. • The clinical review of cases undertaken by experienced independent clinical experts. • Governance and culture, with a ‘Board to Ward’ review of systems, processes and controls. • Staffing and leadership across maternity and neonatal services. • Data and context, including staffing numbers, demographic risk data, incident numbers and outcome data. DC drew the Board’s specific attention to the population health data and associated population-level risks. <p>On <u>engagement with women and families</u>, DC drew attention to:</p> |
|--------|---|



- KS' lead role; his background and experience would be valuable in supporting SBUHB in resetting its family and community engagement methodology and in driving improvements.
- The Family Engagement and Outreach Team had sought to engage people in a number of ways, including through: GP surgeries; local Mosques; traveller communities; the DVLA, as a major employer in the SBUHB area; and sessions in local shopping centres. 1180 women and families had voiced their concerns and experiences, overseen for assurance purposes by a Family and Community Voices Steering Group, with representational family attendance. DC also acknowledged the Llais report and the valuable insights and themes from that; the IR report had incorporated those themes. DC also acknowledged the significant contribution made by the FLR.
- The thematic analysis included all sources of feedback, with the following key findings:
 - Many women reported mostly positive experiences in pregnancy; the report focused on those women who had experienced poor experiences, including severe birth trauma.
 - Whilst many concerns related to the period pre-2024, some experiences were more contemporary.
 - Concerns related primarily to: communication and advice; birth trauma and fear; being ignored and not being listened to; and a lack of compassion. These issues had undoubtedly impacted adversely on informed decision making.
 - Separation from birth partners, both during and in the years following, the COVID-19 pandemic, with a 'rule-bound' approach evident.
 - The views of some seldom heard groups on issues including communication, where a language line alone had proved insufficient to ensure effective communication, together with a lack of cultural awareness and sensitivity. DC emphasised that people had shared their stories because they wanted to work with SBUHB and secure improvements.
 - Families were not moved to attend formal meetings, their preference being to engage in their local, community settings, with SBUHB professionals coming to them to seek their views; this was an important message for SBUHB to hear in resetting engagement arrangements.



- Changes already made included:
 - Changes in SBUHB senior leadership.
 - The Board's recognition of, and apology for, letting women and families down; there was more to do to embed a comprehensive co-produced and co-designed model.
 - Important public statements made by the Chief Executive in recognising the failures; action had to follow.
 - A small number of meetings between the Chair and Chief Executive with a small number of families; these should continue as families appreciated them.

On the clinical case reviews, DC highlighted:

- The methodology adopted, using two multidisciplinary teams, with care assessed against contemporary clinical evidence and standards.
- The ongoing feedback provided to the service on those areas that required urgent action.
- The maternity triage system: this was a high-risk area as the first port of call for women; this needed to improve to ensure that senior experienced staff undertook the assessments.
- The Induction of Labour pathway; this required strengthening.
- Whilst staffing numbers had increased, experienced staff had also moved on to new posts or retired; consequently, the service had a disproportionate number of inexperienced staff requiring senior oversight, with a similar position in the neonatal service.
- Enhanced midwifery care, utilising the Midwifery Early Warning System (MEWS) was in place at the Singleton Hospital site but not yet at other locations; this needed addressing.
- There was a lack of rigour in the conduct of incident reviews; families did not feel engaged with the process and letters received lacked compassion.
- Changes already made included:
 - The recent introduction of the Birmingham Symptom Specific Obstetric Triage System (BSOTS) to assist in categorising and prioritising care; this was a very positive change but further progress was needed on the quality of calls and the monitoring of family experiences. This issue was not unique to SBUHB, with most Care Quality



Commission (CQC) maternity reports in England identifying triage as an area of concern. However, the position in SBUHB required significant and urgent improvement.

- Funding secured to support foetal monitoring capability, supported by clear guidance and pathways.
- Practical Obstetric Multi Professional Training (PROMPT) was now in place, along with development programmes for midwives to enhance competencies.

On Leadership and Staffing the key findings centred on:

- The loss of a number of senior and experienced staff post COVID-19, with low staffing levels impacting on service users.
- Insufficient staffing, leading to incidents.
- A lack of oversight of rosters, leading to incidents.
- Staff inability to attend mandatory training, due to low staffing levels.
- Limited escalation of staff concerns.

- Changes already made included:
 - A significant increase in staffing levels, with the service now close to its staffing establishment levels; however, this did not address the need for more senior and experienced staff.
 - Change in leadership.
 - Significant improvements made in medical workforce numbers.
 - Investment in training, associated with a significant improvement in compliance.
 - A high incident reporting rate; whilst this sounded counterintuitive it demonstrated good follow through. There was more work needed to ensure that this happened for all incidents.
 - Improved feedback for student midwives and trainees.

On Governance the main findings were:

- Significant weaknesses, particularly related to limited staffing and associated risk management.
- The management of debriefs; families reported delays, with the process appearing formulaic. Whilst improvements were evident, families held an overwhelming view that the complaints process was not working.



- The need for improvement in incident investigations, to comply fully with MBRRACE processes.
- Families must be at the centre of investigations.
- Changes already made included:
 - A change to key SBUHB senior leadership posts.
 - Transfer of responsibility and accountability for complaints management to the Executive Director of Nursing.
 - Silver and Gold Command arrangements and enhanced reporting to the Board in greater detail.
 - Improved data capture, through the neonatal dashboard.
 - A debrief process was in place, with further refinements needed.
 - Improved family involvement in the investigation process.
 - Increased staffing levels; this had resulted in a change in the ratio between senior, more experienced and junior, inexperienced staff, and it warranted attention.
 - A reduction in sickness rates.
 - The majority of staff being compliant with mandatory training requirements.
 - A gradual downward trend in MBRRACE data.
 - A significant reduction in Hypoxic Ischaemic Encephalopathy over the past year; detailed analysis of each case was imperative.
 - Positive working relationships reported between maternity, medical staff and neonatal teams.
 - Greater staff confidence in raising concerns, with further requirement necessary.

The Recommendations

Introducing the Recommendations, DC acknowledged the risks associated with the receipt of multiple reports, all of which included recommendations. There was a need for clear ownership, with timelines against delivery and a transparent accountability process. The IR report had a series of recommendations and DC drew particular attention to the corporate recommendations; these required the Board's specific and early attention.

1. Establishment of a single point of access for maternity triage for all women; currently low birth, home pathway and midwifery led maternity fell outside the maternity triage system. This posed a high risk, and the Board should set up a single contact triage



process for all women. There was national guidance available, and the Board should exercise close oversight of the model introduced.

2. Delivery of consistent care with oversight from senior clinical staff across all services, with obstetric procedures overseen by senior and appropriately experienced staff.
3. Implementation of Maternity Early Warning Scores (MEWS) – this was in place at the Singleton site but required roll out.
4. Improvement in the quality of investigations, involving appropriate multidisciplinary reviews, and conducted within reasonable timescales, in line with MBRRACE and serious incident review guidance. There should be a clear trigger for independent or external review.
5. Delivery of compassionate and trauma informed care; recently published literature set out the importance of what families wished to see regarding openness and transparency. Compassionate care should be the norm.
6. Improvements in governance processes, including a complete review of governance and reports that highlight issues clearly to the Board.
7. Attendance by all maternity staff at the all-Wales education programmes on foetal monitoring. DC drew attention to recent developments that would support this.
8. Development and implementation of a robust process for booking and prioritising women undergoing induction of labour; national advice had changed and had to link with information to families.
9. Review and revision of all policies and procedures across maternity and neonatal services to ensure consistent delivery of care.
10. Development and implementation of a wider engagement plan to improve the way that SBUHB engaged with women and families, avoiding an over reliance on surveys.

In addition to these Board-level recommendations, DC took members through a further eleven recommendations designed for Welsh Government (WG) and other national bodies:

1. Review of the Putting Things Right guidance.



2. Introduction of a Harmed Patients Pathway (all disciplines).
 3. Mental health support for women and families; this required an all-Wales approach.
 4. Support for the Welsh Risk Pool to achieve its potential in terms of data, benchmarking, and providing helpful insights, with more resource available to adopt the thematic principles of the Patient Safety Incident Response Framework (PSIRF).
 5. The Maternity and Neonatal Clinical Network lacked clarity in its function between strategy and operations.
 6. A need for a review of the capacity of neonatal critical care services in Wales.
 7. Recent changes to the approach to babies born at extreme preterm gestational ages (less than 24 weeks gestation) in the UK were likely to result in a significant increase in demand for neonatal intensive care.
 8. Healthcare providers and commissioners needed to look actively at high-risk clinical services and seek assurance that outcomes were in line with national standards and that services were safe.
 9. This review had highlighted shortages in paediatric radiology support
 10. Prompt reporting of postmortem results was key to answering questions that bereaved families may have.
 11. The Welsh Government may wish to consider the applicability of the recommendations made within this report to other maternity and neonatal services.
- On next steps, DC commented on:
- The importance of the Board's acknowledgement of harm, acceptance of the responsibility to take action and recognition of the need to improve, to rebuild trust and confidence, with every contact counting. Apologising appropriately was always the right thing to do, recognising that families experiencing trauma may well need more than one conversation.
 - The report included examples of the type of poor care and experience that should never feature in a compassionate service.
 - The IR team welcomed the commitment to continue the conversation, with the self-referral midwife and psychological



support remaining in place to provide advice and support to families needing this.

- KS would continue to work with SBUHB communication team to reset the approach to family and community engagement.

Thanking DC for her comprehensive overview and instructive analysis, JW reflected on just how challenging the report was; she once again offered the Board's apologies to the women and families who had engaged in the IR process, and to everyone whose experience had fallen far short of the required standard. She welcomed the approach taken throughout the IR, namely, to take the information and evidence and use it to support learning and improve experience and outcomes. A learning conference schedule for November would focus on all the learning resulting from the IR, to support SBUHB maternity and neonatal services become the best that they could be.

JW then invited questions and comments.

NM welcomed the presentation; she reflected on her different experiences of three pregnancies, particularly over the COVID-19 period when pregnancy could be a lonely and isolating experience. She empathised with families who had shared their stories and was sorry for their pain. NW shared a recent account when bereaved parents had talked of their use of ear defenders to block out the distressing noise of babies crying. NW supported the need for a dedicated and sensitively located bereavement suite where parents could spend time with their child. SBUHB should work with families to achieve this. She asked (i) what the Board had done to ensure continued support for families and (ii) whether there was a plan in place to reassure pregnant women using the maternity services that the issues highlighted in the IR report would be resolved.

Responding, DC acknowledged the distressing nature of the report; the Board's acknowledgement of the harm and distress experienced, along with the commitment to act, meant that Board members had heard the voices raised during the IR process, and through the FLR. Commenting on bereavement facilities, LR confirmed that plans were under development, recognising that the current arrangements were not acceptable. A better located suite with full soundproofing would be much more appropriate for bereaved parents. On plans to reassure women using the maternity services, LR outlined the work underway to support staff and enable them to have informative and honest conversations with parents.

RT provided contact information on a helpline established for those who had concerns. The helpline number was 01792 986709 and was



available Monday – Friday from 8.30am to 5pm. In addition a specific email address was available for those who preferred to make contact in this way: sbu.maternityenquiries@wales.nhs.uk . The SBUHB website would publicise the details.

ALF took personal responsibility for not being fully sighted on all the serious issues that the IR report had highlighted and she offered families her sincere apologies. ALF reflected on the shortcomings of the Putting Things Right process and the time-consuming nature of managing formal concerns; the disproportionate number of less experienced midwives meant the need for greater senior support and this, coupled with resource pressures, gave ALF cause for concern about meeting families’ rightful expectations.

DC had a different perspective: in her view, earlier and more compassionate interventions and less adversarial discussions could and should prevent issues from escalating and becoming more resource intensive. Although newly qualified midwives would require support for skills development, they should all be able to communicate compassionately.

ALF acknowledged this point, clarifying that her earlier remarks had centred on the more complex cases involving serious harm.

DC commented on the fact that, that whilst effective and compassionate communication was everyone’s business, some hospitals had introduced dedicated staff, who worked proactively to identify concerns at an early stage and to provide speedy redress.

RO expressed her thanks for the detailed and thorough report; she too had found it challenging to read the parts detailing family experiences. RO expressed concerns about ‘Board to Ward’ assurance, and the need to ensure that the Board received relevant information and issues of concern. She also flagged the section in the report on the impact of deprivation and asked what more SBUHB could do at a population health level to address this.

On ‘Board to Ward’ assurance, DC drew attention to recent developments in England that could assist; dashboards had a role and value but were mechanistic data collections and DC emphasised family experiences as being key in capturing the impacts of failure, even in small numbers.

KS recommended a wider and deeper engagement plan and welcomed the Board’s clear commitment to developing this approach. The Board would benefit from a more varied engagement methodology, seeking to engage families and communities across the Swansea Bay area. His work with families had indicated their preference for more a focused



and specific outreach approach; they were unlikely to respond to formal meeting requests.
On population health, DC noted that, whilst pregnancy care required a key but small amount of time for families, population health programmes could cover longer timeframes. Targeted actions in partnership with Public Health Wales (PHW), focused on topics including substance and alcohol misuse, and reaching out to vulnerable and hard to reach groups, would be a positive development.

JW confirmed that she had remitted the section of the report on population health matters to the Population Health Committee for consideration and advice to the Board,

Action: SS/GR

JW thanked DC and KS for responding to questions and comments, she then invited LR to introduce the paper setting out the immediate and planned responses to the IR report, through a comprehensive Improvement Plan.

LR welcomed the intention to engage more effectively with families and was pleased to report on progress to date, acknowledging fully that SBUHB was at an early stage in the improvement journey. She advised the meeting that:

- The MEWS system was in place Singleton Hospital and would roll out across the organisation as soon as possible.
- The Triage process had improved, with plans under development for a 24/7 single point of access dedicated triage point, staffed by experienced and trained midwives.
- There was now daily contact between the maternity unit and multidisciplinary teams.
- Complaints and incidents had transferred to her portfolio, with a clear understanding of the need for meaningful engagement and deep listening. The planned review of the Putting Things Right process offered opportunities to consider organisational wide responses to incidents and complaints.
- The planned all Wales learning event in the Autumn.
- Progress on debriefs, with recognition of more to do.

LR extended her thanks to DC for the report; having the lead executive role for maternity services was a privilege for LR and she would use the report to drive improvements for the future.

JW thanked LR and invited questions:



NZ had found the report a difficult read and it had triggered personal experience; she thanked all families for their preparedness to revisit their trauma. This was a matter of fundamental importance for the Board, and specifically for Independent Members. NZ reflected on the deeper issues of culture and behaviour identified in the report that reflected weaknesses in wider organisational systems. She welcomed the Board's commitment to driving improvement, recognising the need to identify barriers and to understand what a good service looked like. Responding, LR agreed that cultural change underpinned all the planned improvement work. She and TR were working together to explore how best to deliver an open culture that supported staff in speaking out and delivered compassionate care.

TR added detail on the introduction of a 'cultural heat map' designed to capture organisation wide information, using both soft and hard metrics, to identify areas in need of support.

TR also commented on the forthcoming leadership and management development programmes. These would include modules on culture change. JW advised that Workforce and Organisational Development Committee (WODC) would oversee the impact of these programmes.

Action: RO/TR

JC added her thanks to DC and KS and apologised unreservedly for the Board's lack of sufficient oversight in previous years, as this had precluded earlier identification of the key issues highlighted in the IR report. She outlined the reset of the Quality and Safety Committee (QSC), underway currently, and committed to applying its scrutiny role to best effect, with clear visibility from 'Board to Ward'. JC and LR were working together to redesign the style and content of QSC reports, to capture quality and safety issues at all levels across the organisation. QSC meetings would move beyond the receipt of quantitative data, to include qualitative analyses of themes and the interrogation of data against the key Board/Committee level indicators. JC and LR would ensure that QSC operated in line with a robust governance framework.

On Governance, DC referred to the detailed information in the report and the challenge of delivering a robust approach to Governance across a number of Committees. JW confirmed that she, together with Committee chairs and lead Executives, would hold a workshop in the autumn to design a robust process.

Action: JW/HL

AH commented on the broad programme of work underway on the Corporate Governance Framework, to specify greater clarity on roles and responsibilities at all levels in the organisation. Data storage in



different areas across the organisation was a risk, as it generated a silo approach to data analysis, rather than a corporate one. The daily dashboard now available gave the Executive Team more visibility for executives, and this now needed to capture and signal those matters that require urgent attention. DC reinforced the risks associated with individual Committees focussing on different perspectives, when there was a need for collective mitigation of a whole risk. She welcomed the intention to hold a workshop to address this.

Responding to NZ point about what good looked like, LR cited examples across the UK and confirmed the intention to research these and take the learning for the Improvement Plan.

JW then asked MH, Chair of Llais, to comment; in doing so, she reminded the Board of the recent Llais report, and the inclusion of the key themes from that in the IR report. MH welcomed the invitation to the Board meeting and the opportunity to listen to the report findings. MH emphasised that Llais was not a regulator and was independent of government and the NHS; its role was to listen and engage. He welcomed both the IR report and the FLR, published the pervious day. MH also acknowledged the pain and hurt families had experienced over the years and the importance of the Board listening to their voices. MH also welcomed the clear apology to women and families and acknowledgment that SBUHB had got things badly wrong; the IR report reaffirmed systematic failures over the years and he reflected on how painful that must be for those women and families who had experienced a traumatic event. MH stressed the need to work with women and families and support them; he welcomed the focus on improving compassionate care. Llais would challenge the Board to move from aspirational statements to clear organisational change and improvement, utilising engagement as an ongoing process rather than 'one time' action.

MH gave a commitment from Llais to work with the Board and to support all involved; anyone giving birth in Wales had a fundamental right to access safe and compassionate maternity care.

JW thanked MH for his comments and welcomed the offer from Llais of ongoing support for all those involved in the next steps. She was deeply appreciative of that offer, one that SBUHB welcomed.

JW then invited AH to summarise the discussions and make the closing remarks at the end of a hard and emotional meeting.

AH empathised with those women and families whose experiences had formed part of the Family Led Review, the Llais report and the IR report. Reliving those experiences would have triggered strong



emotions and AH thanked them all. She also felt for the staff involved, as this was also a challenging time for them. AH added her heartfelt apologies, her commitment to delivering the improvements needed to secure kind, compassionate care that reflected good practice. The final report was comprehensive, with good quality data to build upon, and a seminal reference point for the Improvement Plan. The population health improvement journey was equally important; the Board needed a more in-depth understanding of the population and the communities that went beyond the analysis available to date. AH referenced the fact that more women from highly deprived communities gave birth in Swansea than in many other parts of the UK and the Board had to understand the implications of this. Whilst the focus of the launch was appropriately on families, AH also recognised that staff wanted to come to work and deliver compassionate care; they needed the right culture and environment to do so and the Improvement Plan would address both. AH confirmed that the September 2025 Board meeting would include an agenda item on the Improvement Plan, and the progress with resetting the approach to family and community engagement, as advised by KS. AH then thanked DC, KS and the whole IR team for their robust and objective report, and for setting out clear recommendations that would enable SBUHB to deliver sustainable improvements. Finally, AH advised that, during the course of the meeting, the Cabinet Secretary had published a statement, escalating SBUHB maternity and neonatal services to the level of 'targeted intervention'. This was one level above that of 'enhanced monitoring'. JW thanked all those whose contributions had informed three hard-hitting, robust and sobering reports. The Board had listened to all those who had found the courage to relive traumatic experiences and JW assured them that their voices would count from now on. The Board:

- **Received** and fully accepted the report, findings and recommendations of the Independent Review.
- **Apologised unreservedly** to all women and families whose care has fallen well below the expected standard.
- **Took assurance** from the initial actions put in place and the arrangements to scope a comprehensive Improvement Plan.
- **Took assurance** from the ongoing independent oversight arrangements.
- **Agreed** to receive a further report at the September Board.

- **Thanked** the Chair and members of the Independent Review Team for their comprehensive and rigorous report.

JW then invited any member of the public to ask any questions or to make any comments.

One observer, who had experienced a traumatic experience, was pleased that the HB had made an unreserved apology, something many parents had wanted for a long time. The observer finally felt listened to and believed; they hoped that the commendations set out in the reports would herald the beginning of real change.

The meeting concluded at 13:26.