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Swansea Bay Perinatal Services

Perinatal Committee

July 2026 Data



Un Bae Ar y Cyd
One Bay Way



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Workforce and Establishment



Un Bae Ar y Cyd
One Bay Way

Workforce – Perinatal services June 2026

ALERT

Workforce fragility remains the dominant operational risk across Perinatal Services, with pressure concentrated in midwifery, neonatal nursing skill mix and neonatal medical rota resilience.

There are material registered workforce gaps in July, including Band 6 neonatal nursing vacancy of 10.57 WTE, alongside Band 6 midwifery vacancies of 11.32 WTE in the Obstetric Unit and Band 3 Obstetric Unit vacancies of 4.68 WTE. The service is also carrying significant workforce unavailability, with Maternity total unavailability at 32.6% and Neonatal total unavailability at 26.98% for July.

The key risk is not only vacancy volume, but capacity and skill mix reliability, particularly where neonatal nursing is described as having a “top heavy junior nursing workforce,” making some shifts difficult to cover despite adequate numbers. Neonatal medical rota gaps are also anticipated from September, with Tier 1 and Tier 2 cover under pressure because of rota redesign and resident doctor contract changes.

ADVISE

The Committee is asked to note the active mitigations in place but also recognise that several controls remain dependent on recruitment approvals, employment checks and sustainable workforce modelling.

Recruitment and mitigation actions are progressing Band 6 neonatal posts are moving through external advert and Annex 21 internal pathways, interviews arranged; Band 7 neonatal appointments are awaiting employment checks; Obstetric Unit Band 3 HCSW appointments have been made; and Band 7 Labour Ward Coordinator recruitment is live interviews planned. Vacancy gaps compounded by sickness, maternity leave and rota change, the service is using bank shifts, flexible rota arrangements and internal rotation to maintain safe staffing. These are temporary controls, not long-term solutions. For example, the slide notes use of bank shifts to mitigate staffing pressures, community support through rotation of two midwives from the obstetric unit, and flexibility in the neonatal medical rota to reduce locum reliance. **Ask:** Committee support is required to maintain pace on vacancy approval, recruitment onboarding, Band 4 and Band 6 bank development, and review of skill mix models to reduce reliance on temporary mitigations.

ASSURE



Service delivery has been maintained, with reported July agency use at 0.0% for both NICU Nursing and Labour Ward. Several posts have been appointed, are live on TRAC, or have interviews planned, providing evidence of recovery actions in progress.

Workforce – Establishments and Vacancies – July 2026

Neonatal Medical Staffing

Grade	Establishment (WTE)	Vacancy
Consultant	11	0
Speciality Doctor	15	1.4 (Tier 2) ➡
8A Nurse Practitioner	4	0
8B Nurse Practitioner	2	0

Neonatal AHP and Specialist Staff

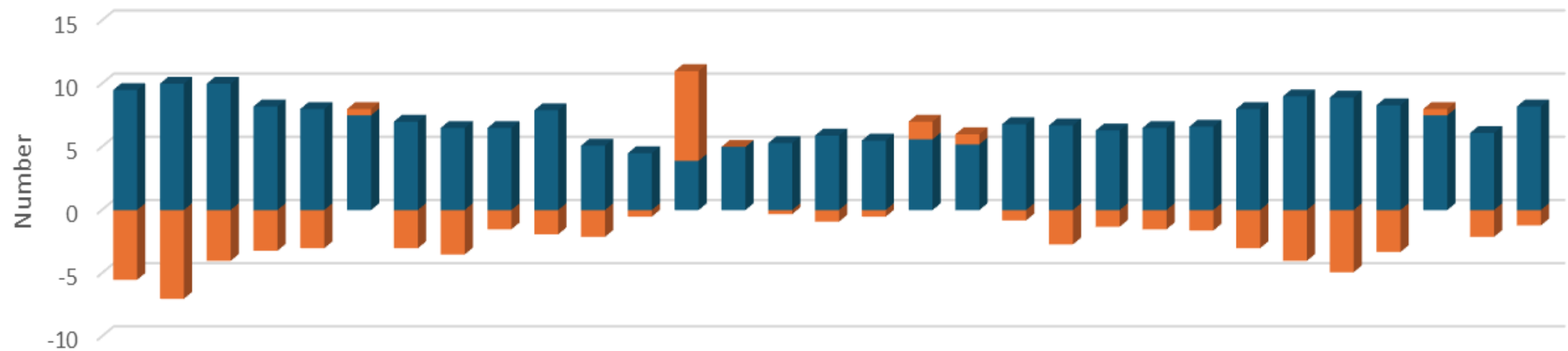
Specialty	Banding	Funded WTE	Vacancy (WTE)	Required BAPM Standard WTE	Shortfall WTE
Speech & Language Therapy	7	0.5	0.0	1.5	1.0
Dietetics	7	0.5	0.5	1.8	1.3
Physiotherapy	7	0.5	0.0	1.85	1.35
Occupational Therapy	7	0.5	0.0	1.45	0.95
Psychology	8b	0.5	0.0	3.24	2.74
TOTAL	-	2.5	0.5	9.84	7.34

Neonatal Nursing**

Band	Establishment (WTE)	Vacancy (WTE)
7	13.92	0 ↓
6	32.09	10.57 ↓
5	36.88	Over 14.64 ↑
4	3.41	0.96 ➡
3	2	0
2 HCSW	2.40	1.6 ➡
2 Admin	2.84	0

- Band 6 posts -1.0 wte to be externally advertised and 8.98 wte under Annex 21 internal, interview day set 19 Aug 11 applicants.
- Awaiting update from Service Group regarding Neonatal Ward Assistant that is with Executive Panel

QIS Day Recommendation Compared to Singleton NICU Difference



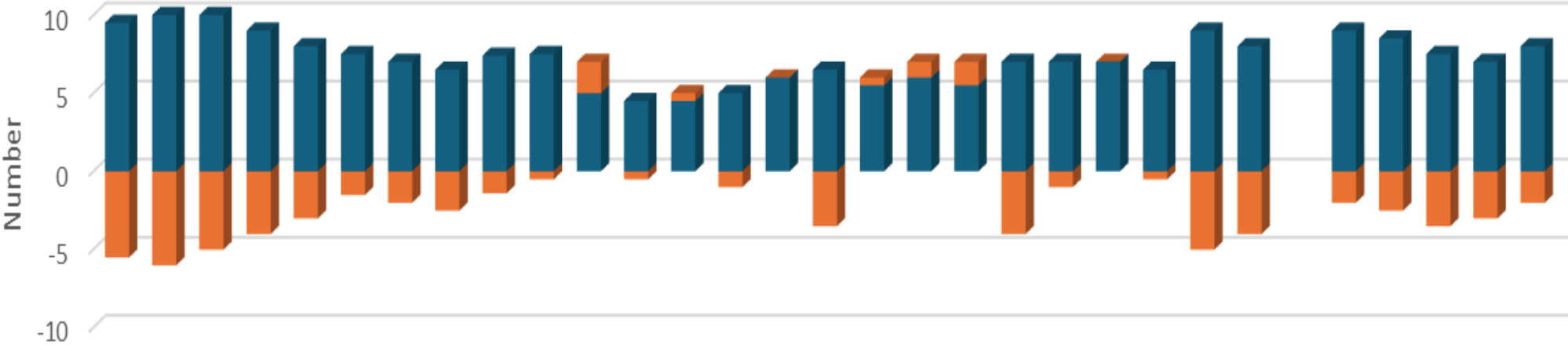
	01-Jul-26	02-Jul-26	03-Jul-26	04-Jul-26	05-Jul-26	06-Jul-26	07-Jul-26	08-Jul-26	09-Jul-26	10-Jul-26	11-Jul-26	12-Jul-26	13-Jul-26	14-Jul-26	15-Jul-26	16-Jul-26	17-Jul-26	18-Jul-26	19-Jul-26	20-Jul-26	21-Jul-26	22-Jul-26	23-Jul-26	24-Jul-26	25-Jul-26	26-Jul-26	27-Jul-26	28-Jul-26	29-Jul-26	30-Jul-26	31-Jul
Diff	-5.5	-7	-4	-3.2	-3	0.5	-3	-3.5	-1.5	-1.9	-2.1	-0.5	7.1	0	-0.3	-0.9	-0.5	1.4	0.8	-0.8	-2.7	-1.3	-1.5	-1.6	-3	-4	-4.9	-3.3	0.5	-2.1	-1.2
Rec	9.5	10	10	8.2	8	7.5	7	6.5	6.5	7.9	5.1	4.5	3.9	5	5.3	5.9	5.5	5.6	5.2	6.8	6.7	6.3	6.5	6.6	8	9	8.9	8.3	7.5	6.1	8.2

 -BAPM Recommendation

 -DIFFERENCE

Top heavy Junior nursing workforce making some shifts difficult to cover skill mix despite having adequate numbers.

QIS Night Recommendation Compared to Singleton NICU Difference



	01-Jul-26	02-Jul-26	03-Jul-26	04-Jul-26	05-Jul-26	06-Jul-26	07-Jul-26	08-Jul-26	09-Jul-26	10-Jul-26	11-Jul-26	12-Jul-26	13-Jul-26	14-Jul-26	15-Jul-26	16-Jul-26	17-Jul-26	18-Jul-26	19-Jul-26	20-Jul-26	21-Jul-26	22-Jul-26	23-Jul-26	24-Jul-26	24-Jul-26	25-Jul-26	27-Jul-26	28-Jul-26	29-Jul-26	30-Jul-26	31-Jul
Diff	-5.5	-6	-5	-4	-3	-1.5	-2	-2.5	-1.4	-0.5	2	-0.5	0.5	-1	0	-3.5	0.5	1	1.5	-4	-1	0	-0.5	-2	-5	-4	-2	-2.5	-3.5	-3	-2
Rec	9.5	10	10	9	8	7.5	7	6.5	7.4	7.5	5	4.5	4.5	5	6	6.5	5.5	6	5.5	7	7	7	6.5	7	9	8	9	8.5	7.5	7	8

 -BAPM Recommendation

 -DIFFERENCE

Workforce – Establishments and Vacancies – July 2026

Obstetric and Gynaecology Medical Staffing- including Gynaecology Oncology

Grade	Establishment (WTE)	Vacancy
Consultant	22	0
Speciality Registrar	13	0

Antenatal Clinic

Band	Establishment (WTE)	Vacancy (WTE)
Neath	3.57	0
Singleton	7.83	1 →

Midwifery – community

Band	Establishment (WTE)	Vacancy (WTE)
Band 7	8	0
Band 6	37.48	0.31
Band 3 (MSW)	5.69	0.45
Band 3 (MCA)	6.8	1.8

Midwifery – Obstetric Unit

Band	Establishment (WTE)	Vacancy (WTE)
7	12.96	1.28 →
6	74.36	11.32 ↓
5	17.72	
4	8.53	2.13 →
3	25.59	4.68 →
2	5.69	1.69 →

Newly Qualified Midwives commence in service at band 5 with progression to band 6 expected. The current over establishment at band 5 will reduce the band 6 vacancy.

Appointment of 4 Middle Grades & 1x Obs & Gynae Consultant

Unavailability Data – July 2026

Data Source – RosterPerform©

Neonatal services

	Dec-25	Jan -26	Feb -26	Mar -26	Apr -26	May-26	Jun -26	Jul –26
Total Unavailability	30.5%	19.6%	31.8%	31.4%	30.3%	26.2%	30.5%	26.98%
Parenting	3.2%	3.5%	3.6%	3.0%	2.7%	2.2%	1.9%	1.54%
Annual leave	15.5%	7.3%	17.8%	18.4%	15.7%	13.8%	16.6%	15.65%
Study Leave	3.6%	0.6%	1.7%	1.4%	3.0%	1.9%	1.9%	0.36%

Maternity Services

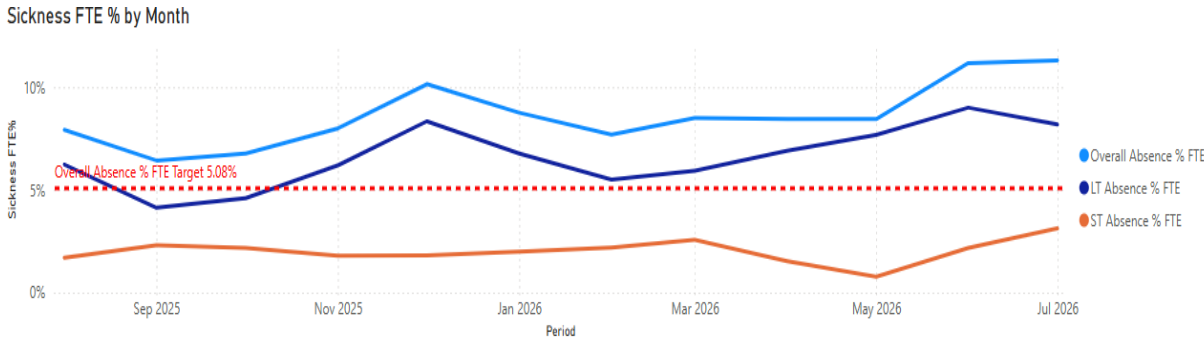
	Dec 25	Jan -26	Feb -26	Mar -26	Apr -26	May 26	Jun -26	Jul –26
Total Unavailability	30.6%	24.7%	30.3%	31.7%	29.5%	30.8%	33.1%	32.6%
Parenting	5.7%	5.9%	5.9%	4.7%	6.1%	2.2%	7.0%	6.10%
Annual leave	14.4%	10.8%	13.5%	15.6%	12.4%	13.2%	13.8%	14.54%
Study Leave	4.5%	1.6%	4.3%	7.3%	2.2%	3.3%	1.2%	0.80%



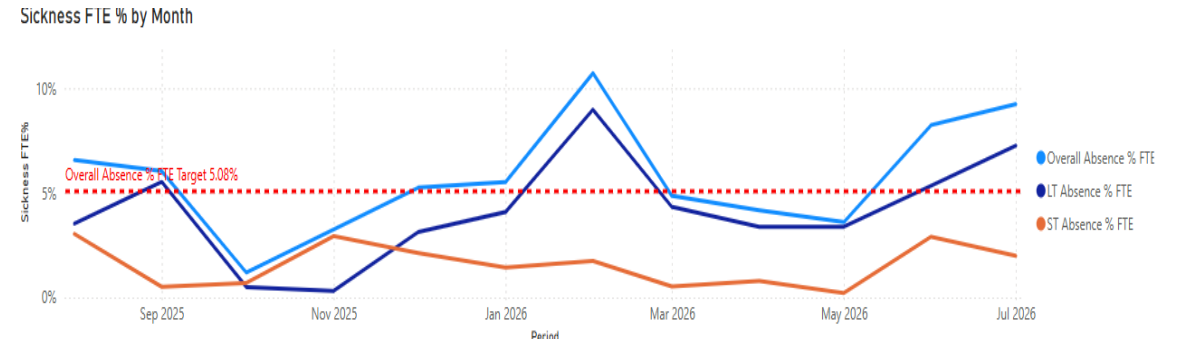
Area	Total Bank/Agency use	Agency Use	Agency % of temp staffing
NICU Nursing	11.9%	0.0%	0.0%
Labour Ward	1.2%	0.0%	0.0%

Sickness FTE % by Month – July 2026 Maternity

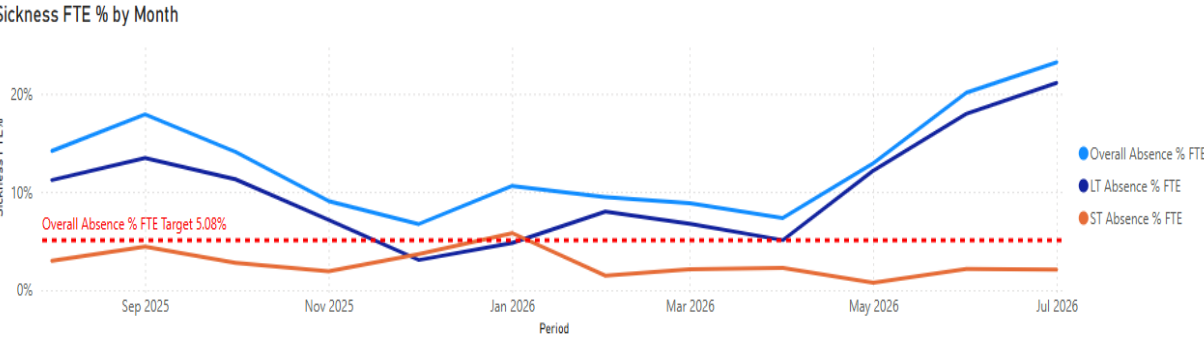
Registered Midwives



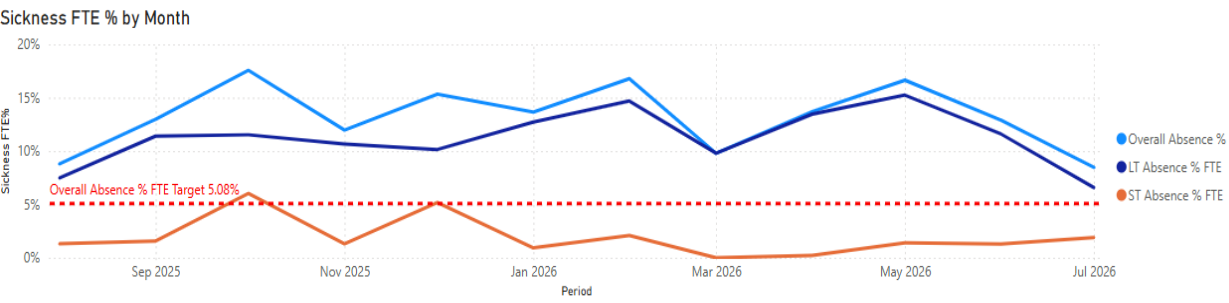
Medical Staff



Additional Clinical Services



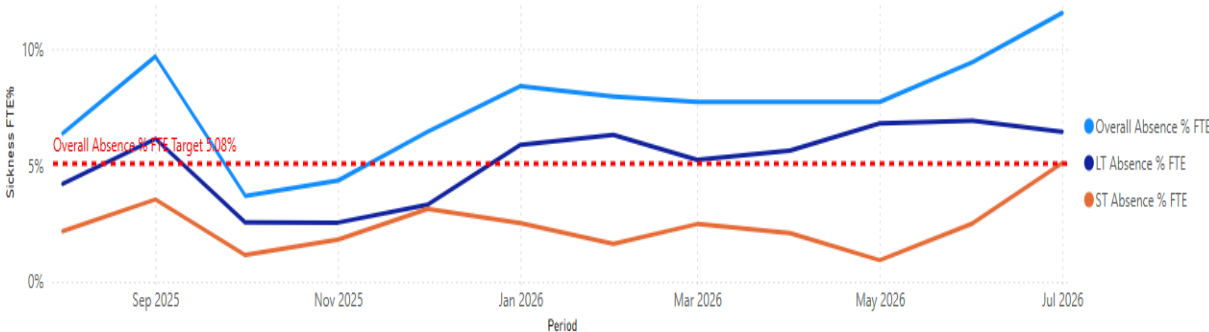
Admin and Clerical



Sickness FTE % by Month – July 2026 - Neonatal

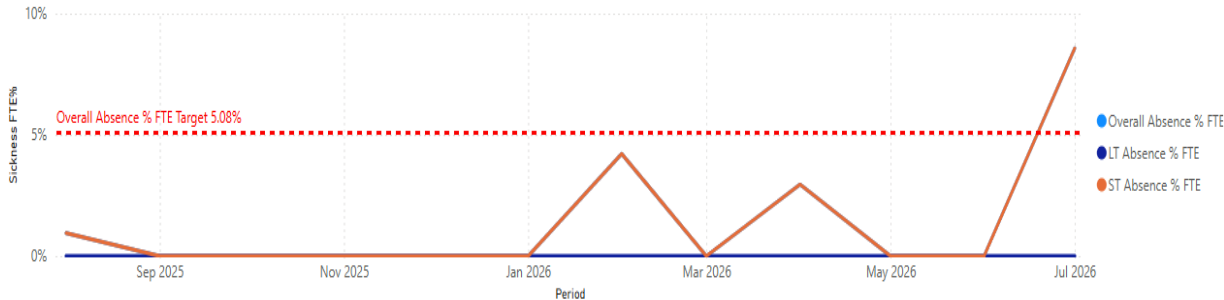
Registered Neonatal Nurses

Sickness FTE % by Month



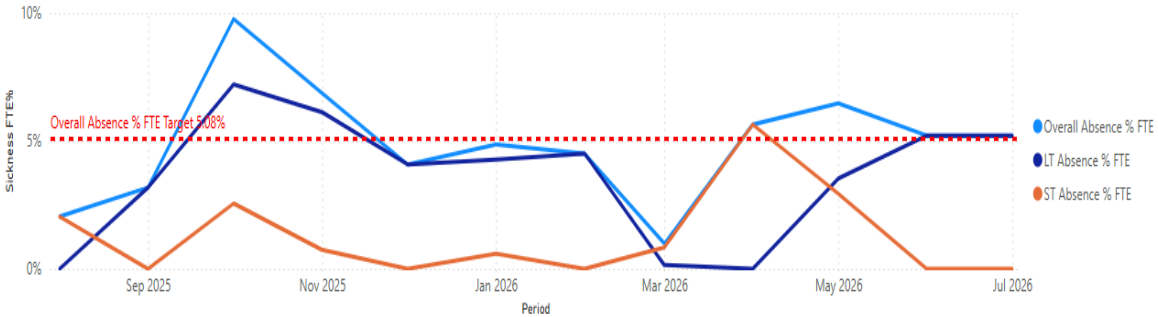
Additional Clinical Services

Sickness FTE % by Month



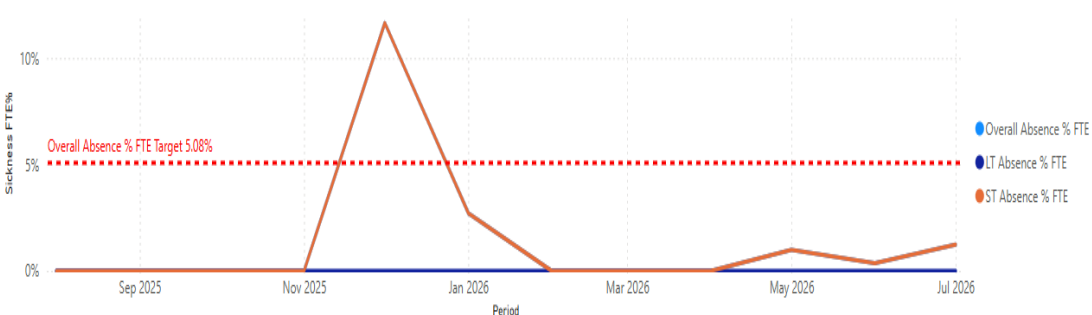
Medical Staff

Sickness FTE % by Month



Admin and Clerical

Sickness FTE % by Month



Training and Compliance

Perinatal Services – Training and Compliance – June 2026

ALERT

Residual risk exists around specialist competency training (GAP/GROW, MoNET and QIS access), largely driven by workforce capacity constraints and national training dependencies.

ADVISE

Recovery plans are in place with active monitoring, escalation and executive oversight of areas below target.

ASSURE

System-wide compliance remains strong, with most workforce groups exceeding Welsh Government requirements and maintaining core safety competencies.

Perinatal workforce Training and Compliance – July 2026

Statutory and Mandatory Training		June - 25	July - 25	Aug - 25	Sept - 25	Oct - 25	Nov - 25	Dec - 25	Jan - 26	Feb – 26	Mar - 26	Apr - 26	May - 26	June - 26	Jul – 26
* Welsh Government Target 85%															
Medical Staff	Obstetric	78%	91%	85.4%	81%	81.0%	85.4%	88.95%	89.95%	89.95%	88.32%	89.98%	89.98%	91.40%	90.38%
	Neonatal	87.1%	86%	84.8%	76.3%	80.4%	88.63%	88.92%	88.92%	93.14%	94.12%	95.89%	95.89%	94.74%	95.36%
Additional Clinical Services	Maternity	92.9%	94%	93.5%	91.5%	91.5%	93.0%	93.0%	91.73%	91.73%	91.51%	91.11%	91.11%	93.84%	92.87%
	Neonatal	100%	100%	100%	97.3%	97.3%	97.3%	97.3%	97.37%	97.37%	93.42%	94.74%	94.74%	96.05%	98.68%
Nursing and Midwifery	Maternity	95.5%	96%	96.1%	94.8%	94.8%	95.4%	95.4%	94.92%	94.92%	92.95%	95.01%	95.01%	95.16%	94.89%
	Neonatal	95.2%	95%	95.6%	92.4%	92.4%	95.2%	95.2%	95.81%	94.49%	93.33%	95.89%	93.33%	96.41%	96.83%

Workforce – Training Compliance - July 2026

NLS Neonatal Training	Sep-25	Oct-25	Nov -25	Dec -25	Jan 26	Feb -26	Mar 26	Apr -26	May -26	Jun -26	Jul –26
Nursing	95%	88%	88%	87%	87%	87%	92%	92%	92%	96%	96%
Consultants	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Juniors - Tier 1	90.9%	90.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Juniors - Tier 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Nurses Qualified in Speciality	Sept -25	Oct -25	Nov –25	Dec 25	Jan 26	Feb 26	Mar 26	Apr -26	May 26	Jun 26	Jul -26
Module 1	59.0%	59.0%	59.0%	51%	51%	51%	51%	51%	51%	51%	51%
Module 2	59.0%	59.0%	59.0%	51%	51%	51%	51%	51%	51%	51%	51%

NLS figures will improve in March 2026, with two scheduled training courses.

MoNET training	Compliance end of June
Consultants	0%
T1 + T2	0%
ANNP	0%
Band 7	0%
Band 6	0%
Band 5	0%
Total	0%

QIS figures unchanged.
5 neonatal nurses currently completing the QIS modules at 50% study leave due to staffing pressures. Planning to offer more places next year at risk.

MoNET training 0% due to plan new programme originally scheduled for January 2026. Training day's have been cancelled in since January, with predicted cancellation until January 2027.

Workforce – Training Compliance – July 2026

Maternity Training		Sept - 25	Oct- 25	Nov -25	Dec 25	Jan 26	Feb 26	Mar-26	Apr - 26	May 26	Jun - 26	Jul - 26
Prompt	Obstetric Medical Staff	100%/92 %	95%	95%	95%	96%	95%	96%	97%	96%	96%	96%
	Midwifery	97%	95%	91%	91%	97%	97%	96%	97%	96%	97%	95%
	Anaesthetics	100%	100%	98%	98%	98%	97%	98%	97%	98%	83%	85%
	Community PROMPT			96%	93%	94%	94%	97%	97%	97%	96%	95%
Fetal Surveillance		99%	88%	98%	98%	98%	98%	100%	99%	99%	99%	97% (MWs)
Maternity Workshop				14%	20%	32%	39%	45%	52%	57%	63%	86%
NLS		96%	94%	94%	96%	97%	97%	97%	98%	97%	97%	98%
Gap Grow	Obstetric	71%	75%	88%	100%	100%	100%	92%	100%	100%	100%	
	Midwives	86%	90%	89%	89%	90%	92%	85%	87%	81%	81%	85%

Safeguarding	Safeguarding People (F2F)	VAWDASV
Midwives	96.23%	95.73%
Obstetricians	87.76%	90.32%

Maternity workshop noted to be low in compliance as training day implemented in November 2025 but a continuous improvement is evident .

JOB PLANNING

TIME PERIOD	13th of July 2026			
SPECIALTY	APPROVED	AWAITING FIRST SIGN OFF	FURTHER DISCUSSION REQUIRED	DUE TO BE JOB PLANNED
Obs and Gynae	10	1	12	ALL
Neonates	10	2	1	ALL

Updated Position

- Neonates Job Plans to be undertaken later in the year following development of revised rota for 2027
- Obs & Gynae Job Plans to be undertaken as part of organisational change process due to Workforce Redesign



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Infection, Prevention and Control



Un Bae Ar y Cyd
One Bay Way

Perinatal Services – Infection, Prevention and Control

ALERT

Domestic cover in the afternoons in Obstetric Unit – with site

ADVISE

Targeted action plans, enhanced Matron oversight, peer review audits and AMAT monitoring are in place to address identified risks and strengthen compliance.

All actions on ward 19 action plan complete

ASSURE

No Tier 1 infections in 2026, no reported bloodstream infections or C. difficile cases in July and sustained high compliance across most clinical audit measures provide assurance of effective infection prevention systems.

Bi-quarterly validation IPC Corporate Inspection – Maternity Services

Area	October 25	November 25	June 26
Labour Ward	Not inspected	53.3%	86.7% ↑
Ward 20 - Postnatal	40%	66.67%	80% ↑
Ward 19 – Antenatal	46.7%	73.33%	33.3% ↓

Postnatal ward improvement plan ongoing. Actions uploaded to AMAT in January 2026 – Therefore a high number of ongoing actions in comparison to other areas. Improvement plan to complete ongoing actions ongoing with Senior support from Deputy Head of Midwifery. Plan for monthly meetings to review ongoing and overdue actions.



AMAT Action Plan			
Ward	Overdue Actions	Ongoing Actions	Completed Actions
Labour Ward	0	1 ↓	7 ↑
Ward 19 - Antenatal	0	0 ↓	7 ↑
Ward 20 - Postnatal	6 ↑	6 ↓	8 ↑

The Maternity Quality Assessment Tool

On review – some of the areas were not applicable to Maternity – nutrition assessments, oral care. This is to be reviewed to ensure it is specific and suitable for reviewing the service.

Safeguarding – this was based on ESR recording of evidence. The service has confirmed safeguarding levels. ESR compliance for safeguarding in HB as training is updated manually. Referred to Head of Safeguarding for review.

All actions from the review have been uploaded to AMAT and Maternity continues a bi-monthly infection control meeting in place, with delegation of responsibilities to Matrons and Ward Managers – next meeting will be arranged prior to divisional meeting so any issues can be captured in the divisional report

Infection Prevention and Control – July 2026

🕒 HCAI rates within maternity and neonatal services to national targets

🕒 C. difficile NPTSSG

- 🕒 NICU - 0 cases
- 🕒 Maternity – 0 cases

🕒 E. coli Bacteraemia

- 🕒 NICU – 0 cases
- 🕒 Maternity – 0 cases

🕒 Klebsiella Bacteraemia

- 🕒 NICU – 1 case
- 🕒 Maternity – 0 cases

🕒 Pseudomonas aeruginosa Bacteraemia

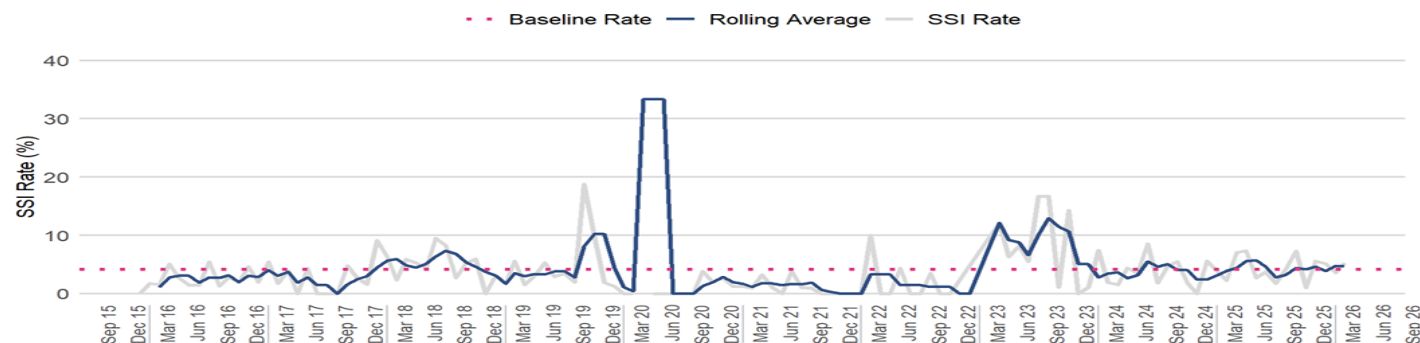
- 🕒 NICU – 0 cases
- 🕒 Maternity – 0 cases

🕒 Staph. aureus Bacteraemia

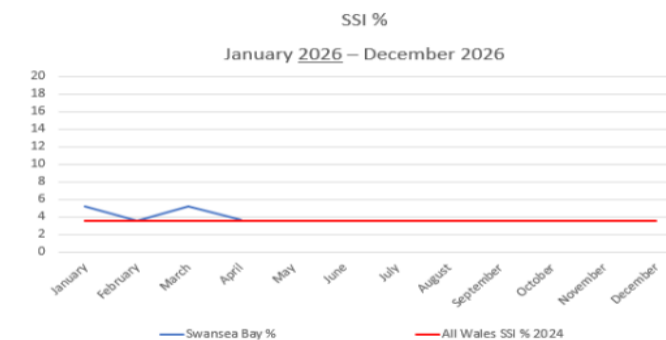
- 🕒 NICU – 0 cases
- 🕒 Maternity – 0 cases

🕒 Overview of SSI position and variance

- 🕒 July 2025 – SSI rate is 5.66%
- 🕒 August 2025 – SSI rate is 1.79%
- 🕒 October 2025 – SSI rate is 13.64%
- 🕒 November 2025 – SSI rate is 7.29%
- 🕒 December 2025 – SSI rate is 6.48%
- 🕒 January 2026 – SSI rate is 5.17%
- 🕒 February 2026 – SSI rate is 3.60%
- 🕒 March 2026 – SSI rate is 5.26%
- 🕒 April 2026 – SSI rate is 3.70%
- 🕒 May 2026 – Outstanding
- 🕒 June 2026 – Outstanding
- 🕒 July - Outstanding



HARP confirmed definition of SSI is <14 days for reporting. Therefore to report SSI <14 days from January 26. To continue data collection for SSI reported >14- <28 days due to ongoing QI project.





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Incident Review and Management



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One Bay Way

Incident and Governance – July update monthly

ALERT

Delays in external reviews, pathology reports and system dependencies continue to impact the timeliness of incident closure and learning delivery to families.

ADVISE

Historic incidents are being actively prioritised for closure, LFER processes have been introduced, and alternative approaches to external review provision are being explored.

ASSURE

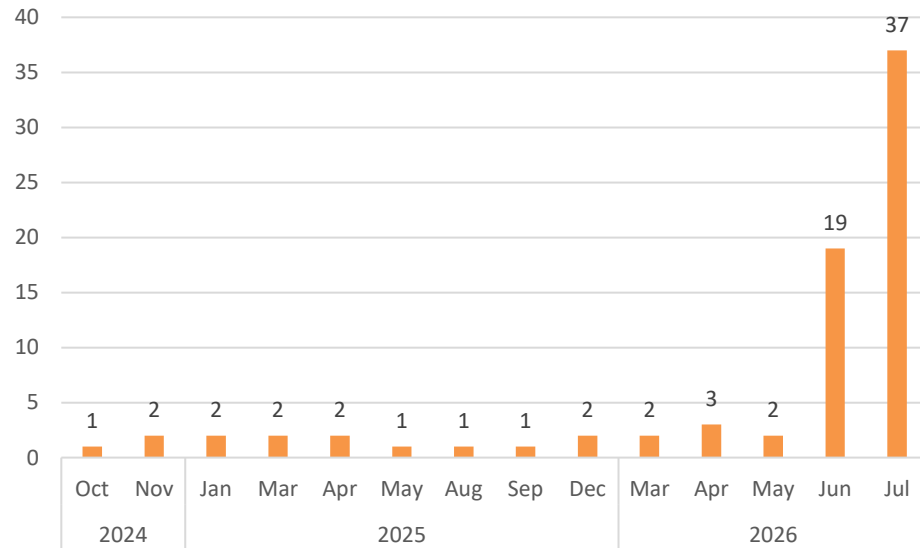
Governance arrangements continue to mature, with stronger multidisciplinary learning systems, improved family-centred review processes and active management of open investigations.



Un Bae Ar y Cyd
One Bay Way

Maternity Incidents – As at 03.08.2026

Total incidents open – 77 (as at 03.08.2026)



The 77 incidents currently open include:-

- 31 - Incidents relating to unexpected admissions to NICU.



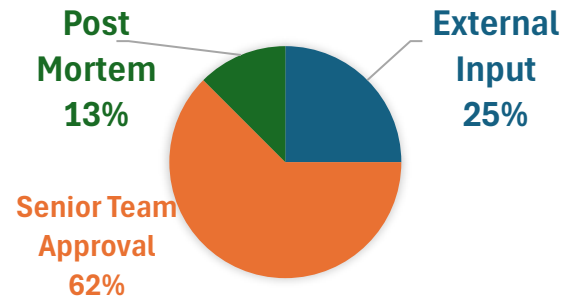
Oldest incidents

2024

- October 2024 – INC 65081 – Response finalised and signed off
- November 2024 – INC 68634 – Response awaiting approval
- November 2024 – INC 68635 – Response awaiting approval

2025

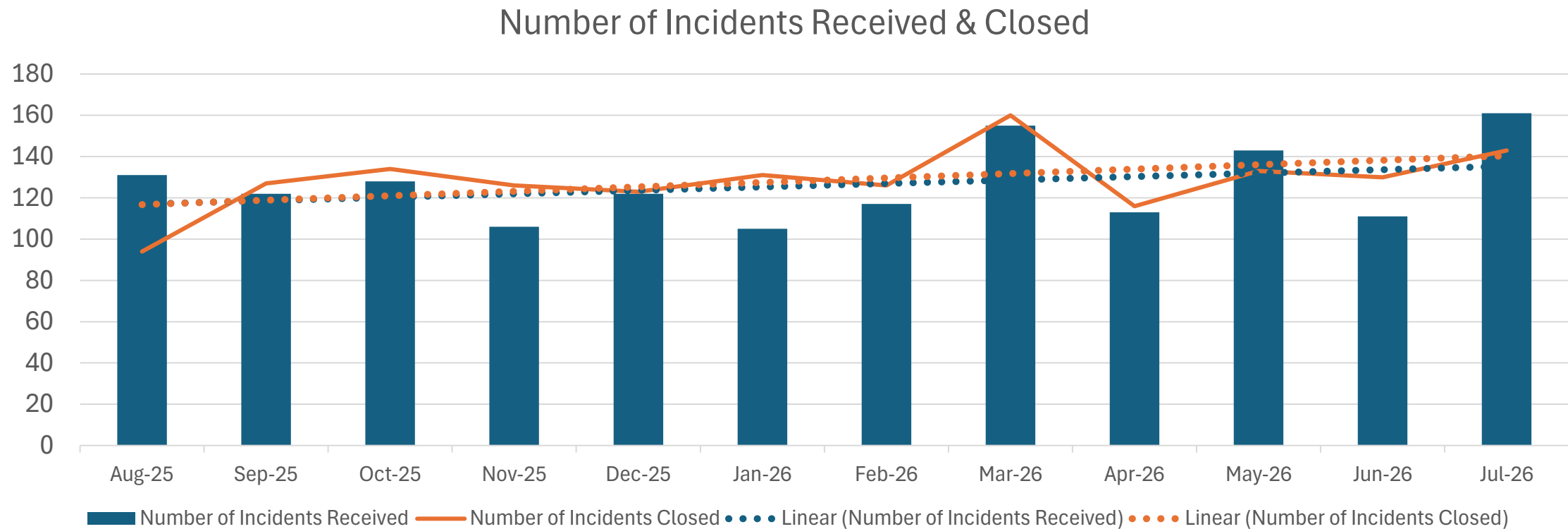
- 4 Incidents logged for historic issues with Kleihauer results – Under investigation – for closure by ASW lead- closed
- April 2025 – ID 110681 – Indirect Maternal Death – closed.
- April 2025 – ID 79285 – External review – awaiting reports
- May 2025 – ID 80896 – External review – 1 report received.
- August 2025 – ID 87052 – Awaiting IR3 approval by NA & TE
- September 2025 – ID 89315 – Awaiting IR3 approval – TE & NA
- December 2025 – ID 95554 – Report sent to KG and SB for sign off
- December 2025 - ID 96260 – Awaiting IR approval by NA & TE



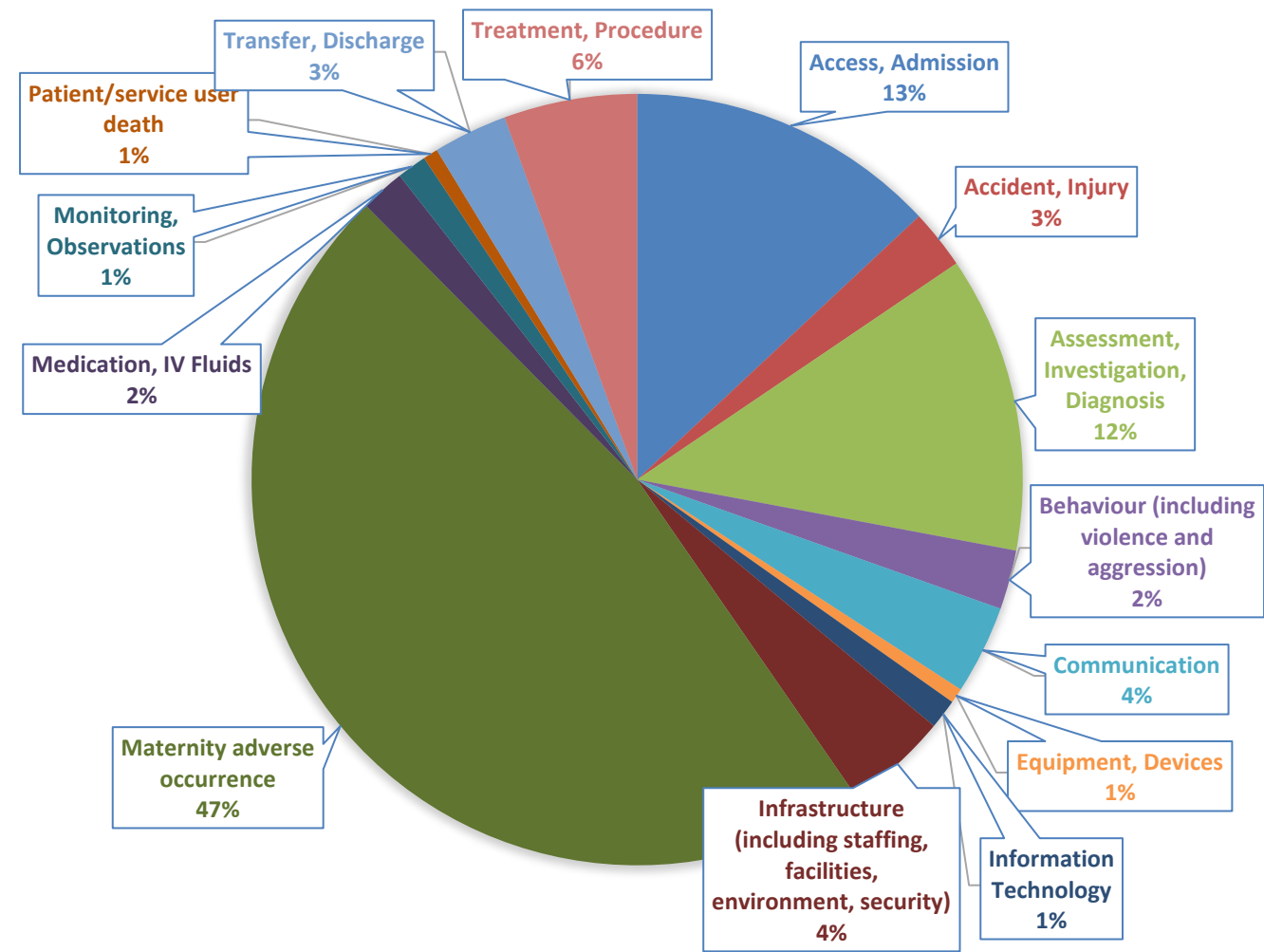
Maternity Incidents – Activity over 12 months

Total number of new incidents received in June - 161

Out of which, 121 incidents have been closed following investigation



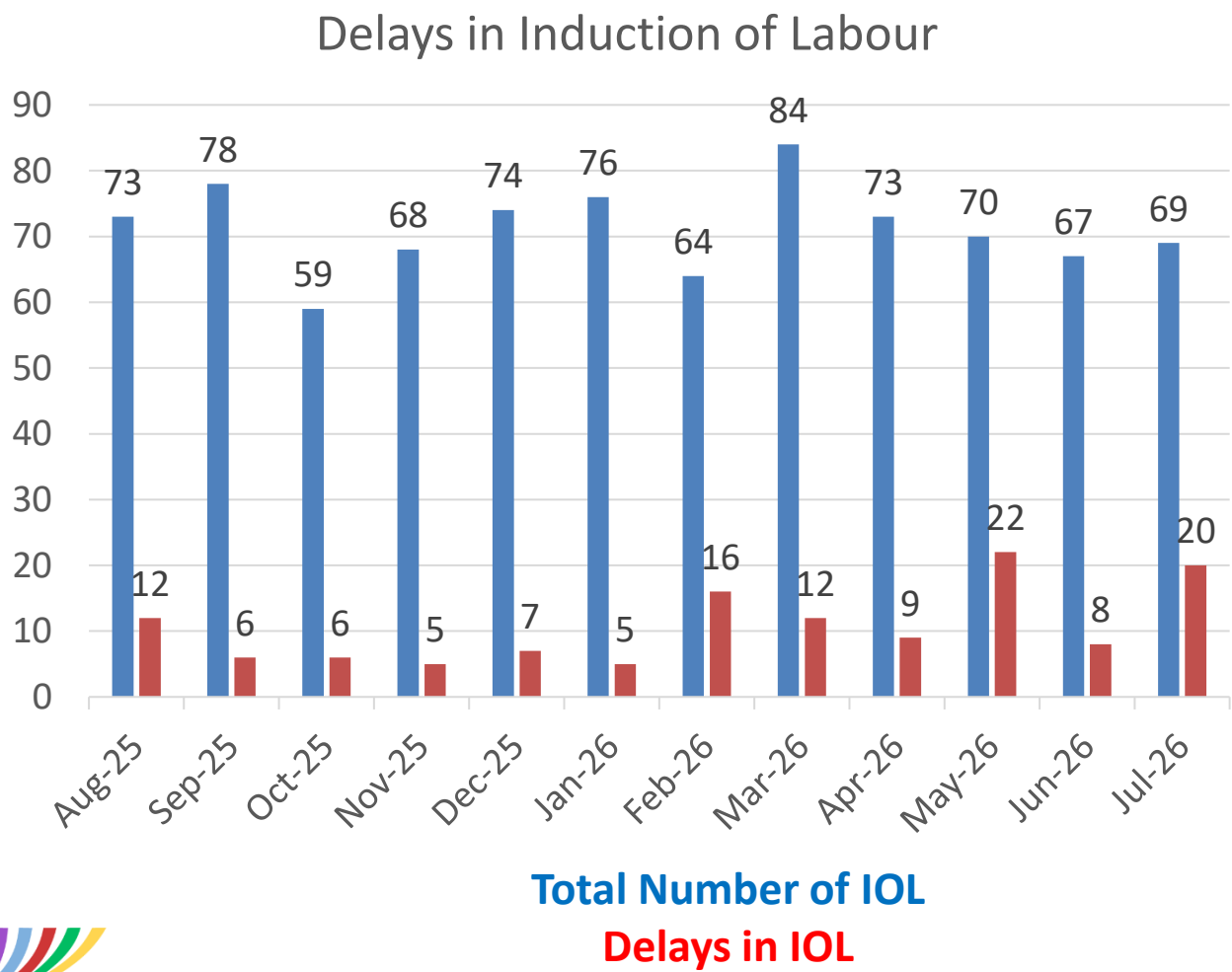
Incident review – Maternity Newly Reported Incidents: 01/07/2026 – 31/07/2026



Maternity Adverse Occurrences:	
Sub-categories	Number of incidents
Baby unexpected admission to neonatal unit (gestation up to 36 weeks)	1
Congenital anomaly	1
Cord prolapse	1
Delivery of baby born below 10th centile	12
Delivery of baby with no professional in attendance (e.g. Born before admission (BBA))	1
Major post-partum haemorrhage (> 1500mls)	7
Postponement / delay of induction of labour or elective procedure	20
Shoulder dystocia	6
Third or fourth degree tear	5
Unexpected admission to neonatal unit (gestation 37 weeks+)	22



Delays in Induction of Labour – Activity over 12 months



Induction of Labour

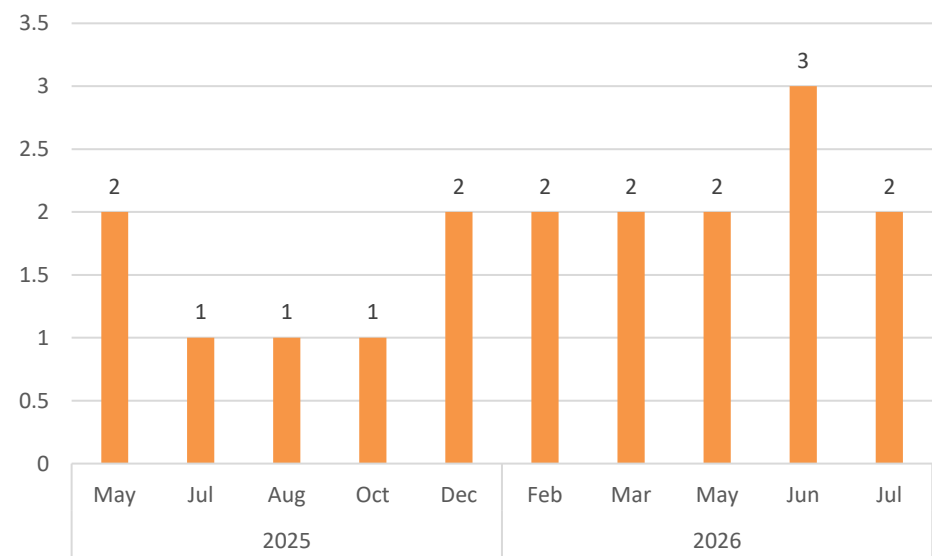
20 Delayed induction of labours reported for July 2026.

Ongoing work regarding review of induction of labour to include risk stratification of induction of labour, review of induction of labour and thematic review of delays.



Neonatal Incidents - As at 03.08.2026

Total Numbers of incidents open – 18 (as at 03.08.2026)



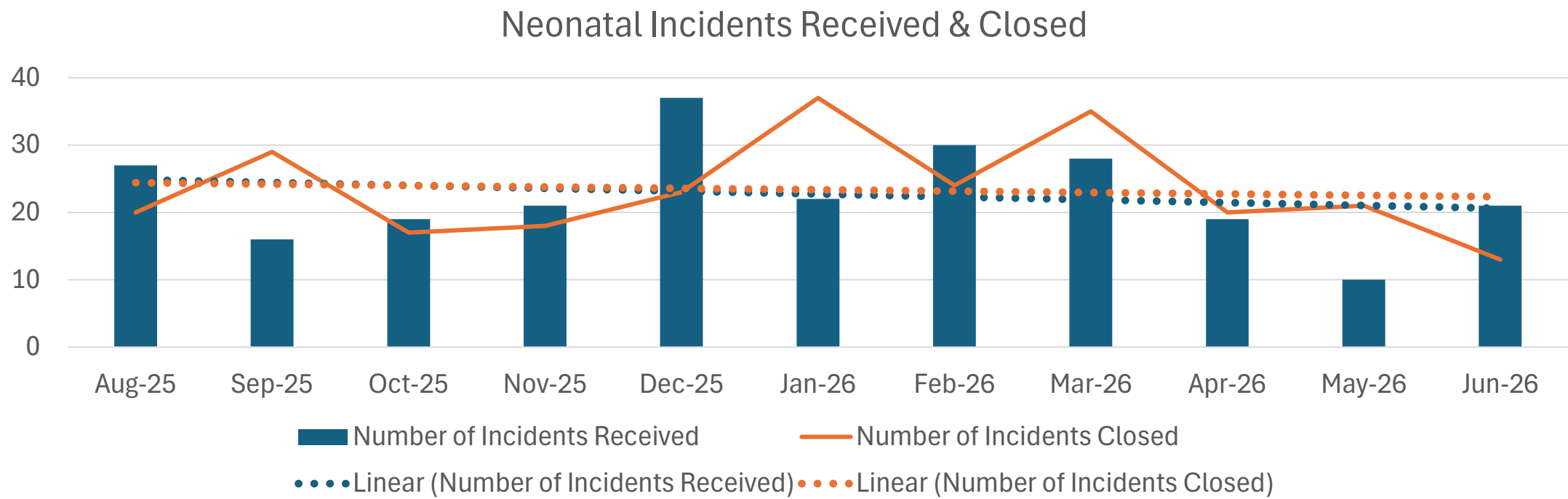
2025

May 2025 – ID 81205- external review
May 2025 – ID 81404- NN review completed- maternal external witness reports being reviewed
July 2025 – ID 84933- linked 81205 (external review)
Dec 2025 – ID 95927 linked to Maternity incident 95554 – Awaiting PM to finalise investigation
Dec 2025 – ID 111068 – Staff injury investigation ongoing

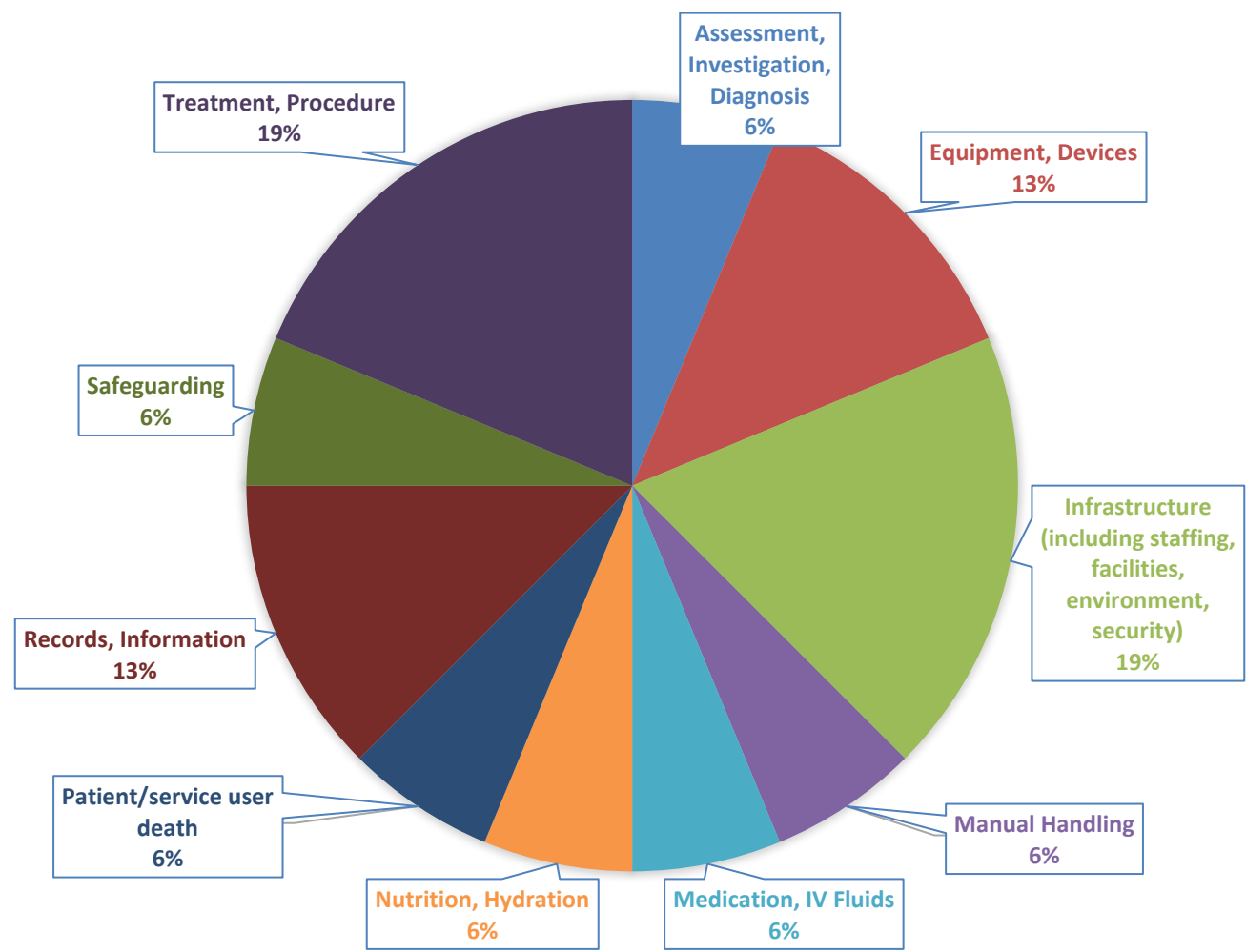
Neonatal Incidents – Activity over 12 months

Total number of new incidents received in July – 16

Out of which, 9 incidents have been closed following investigation



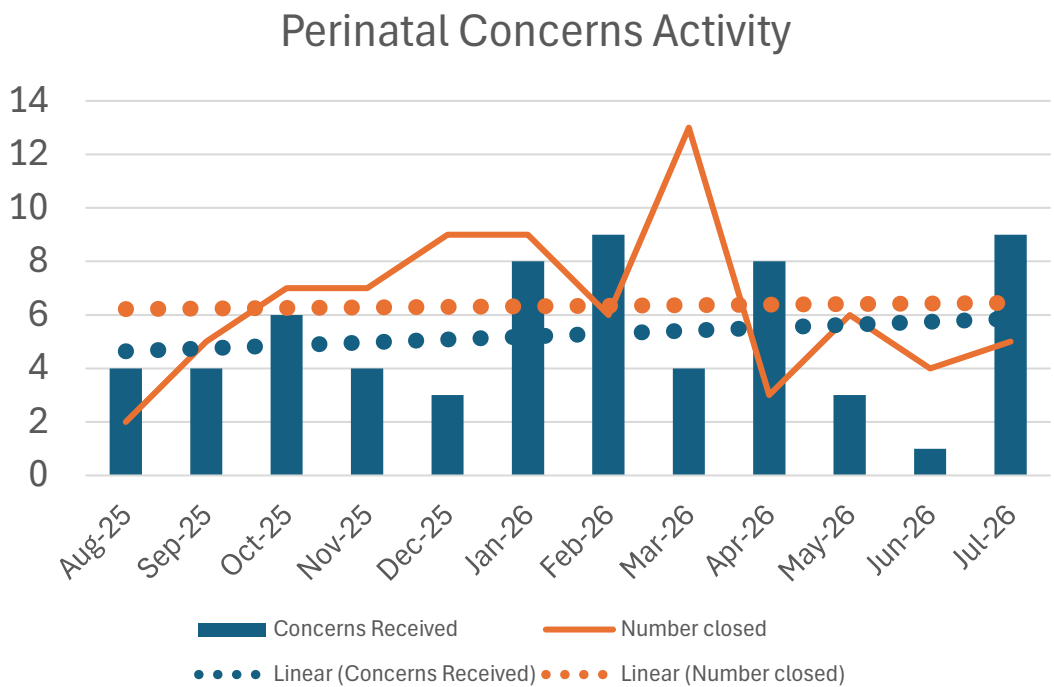
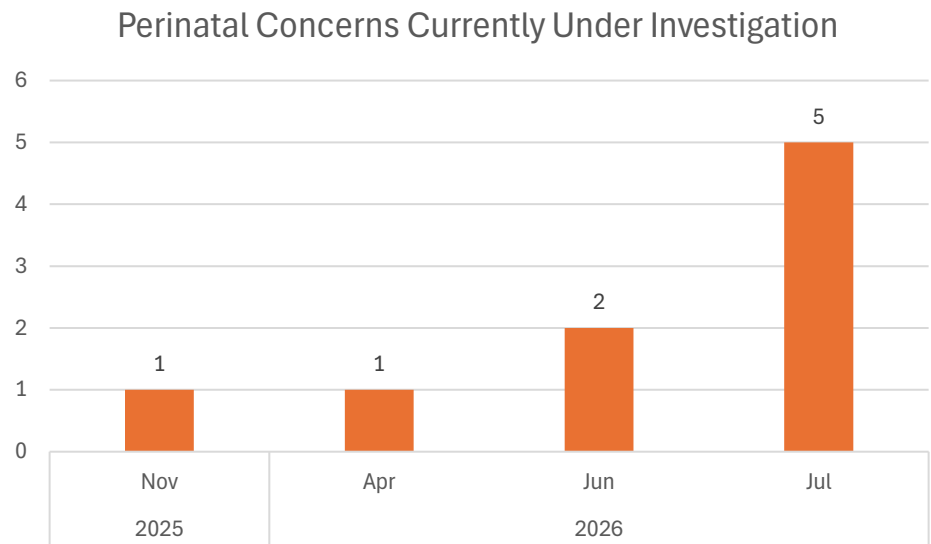
Incident review – Neonatal Newly Reported Incidents: 01/07/2026 – 31/07/2026



Categories	Number of Incidents
Assessment, Investigation, Diagnosis	1
Equipment, Devices	2
Infrastructure (including staffing, facilities, environment, security)	3
Manual Handling	1
Medication, IV Fluids	1
Nutrition, Hydration	1
Patient/service user death	1
Records, Information	2
Safeguarding	1
Treatment, Procedure	3



Perinatal Concerns Outstanding – As at 03.08.2026



- Perinatal Services have 9 open concerns – 2 of which are currently overdue:-
- 1 response awaited from External Investigation Team response (chased)
- 1 response awaiting Paediatric approval

Perinatal Concerns – Breakdown of Concerns

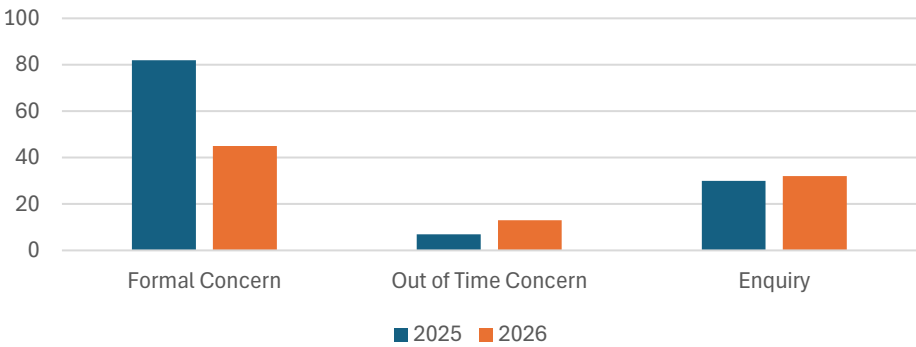
Date	Progress of Concern	Overdue
6 th November 2025	Response awaited from External Review Team – Chaser sent to corporate services	Yes
21 st April 2026	JOINT Perinatal & Paediatric Concern, Paediatric response is awaiting approval	Yes
25 th June 2026	Under investigation	No
29 th June 2026	Under investigation	No
2 nd July 2026	Under investigation	No
20 th July 2026	Awaiting further patient contact	No
27 th July 2026	Under investigation	No
29 th July 2026	Under investigation	No

Outside of PTR

- 1 early resolution – contact being made
- 2 meetings being arranged to discuss out of time concerns

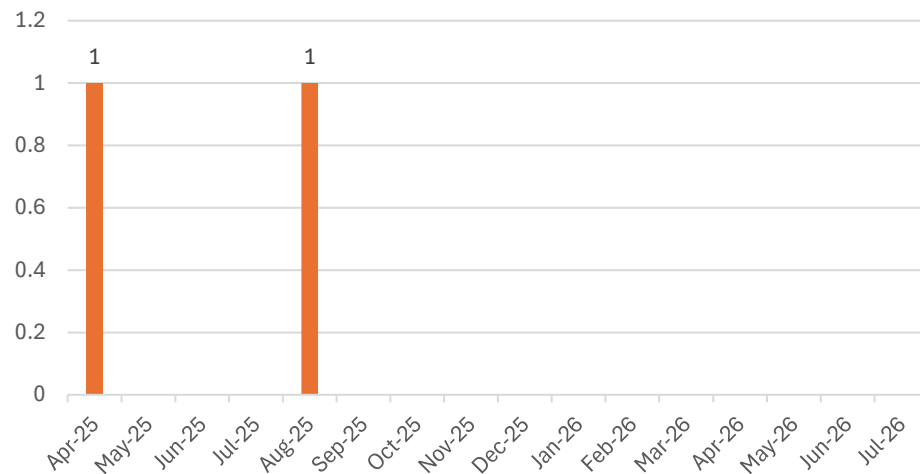


Breakdown of Maternity Concerns



Perinatal DoC cases – as at 03.08.2026

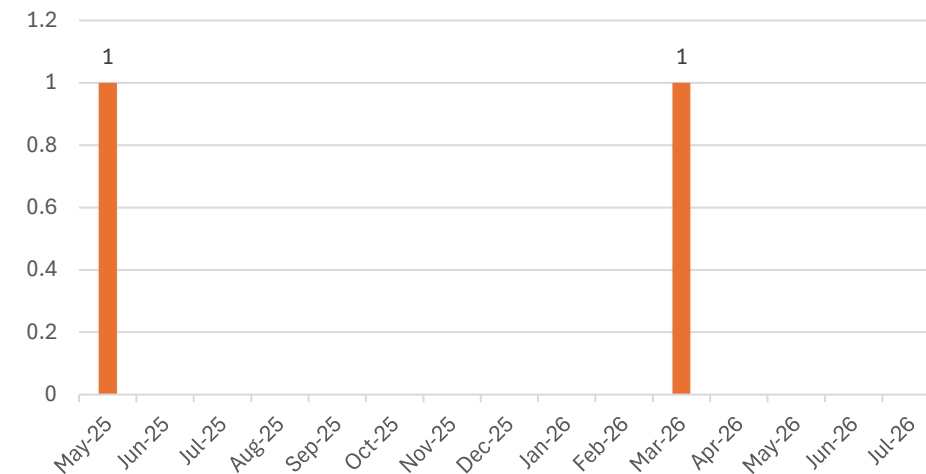
Maternity DOC Cases open



Maternity

- April 2025 – ID 79285 – Awaiting External review report.- anticipated 12 weeks.
- August 2025 – ID 87052 – Awaiting Neonatal HIE review sign off with TE and NA.

Neonatal DOC Cases open



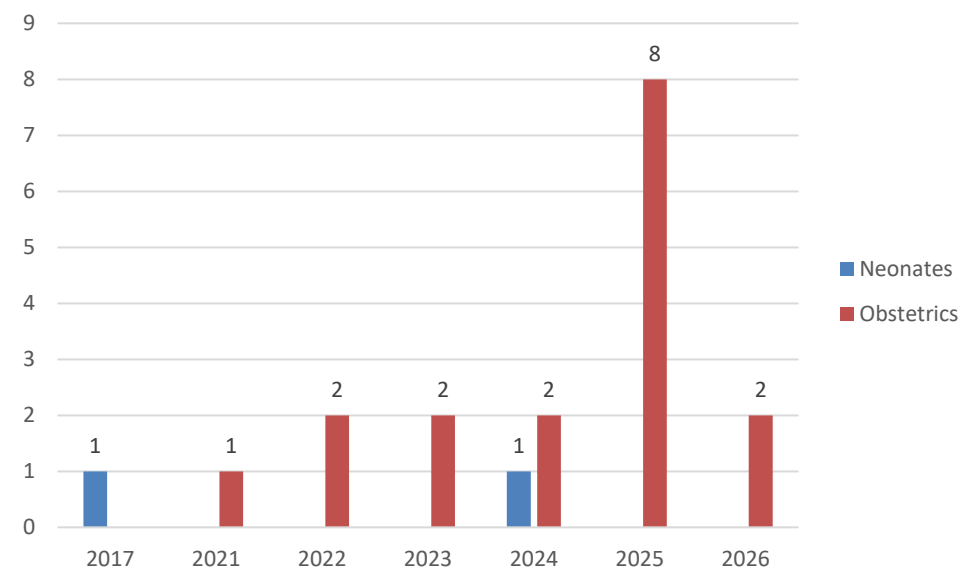
Neonates

- May 2025 ID 81205- Treatment caused injury to baby – External review
- March 2026 – ID 102241 – Dusky limb colour on toes of both feet – investigation ongoing

Maternity Services action to focus on Duty of Candour incidents – remained open longer than 30 days due to complex reviews. Action to close these as priority.

REDRESS – As at 03.08.2026

Number of Redress cases currently open for Perinatal Services as at 03.08.2026



- There are currently 19 Redress cases open
- 12 Redress cases are as a result of incidents being investigated
- 7 Redress cases are as a result of concerns being investigation

Risky Business Newsletters



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Risky Business

Maternity Clinical Risk and Governance

Incidents from – April, May and June 2026

Labour ward	Pressure/moisture skin damage incidents: Unfortunately, even after the implementation of Purpose-T within the health board, in April we had another case of significant pressure/moisture damage being dealt with under DOC. The woman had been a PFROM on the antenatal ward, was then immobile throughout her labour with an epidural until birth by LSCS. Following birth, the woman remained immobile for a further 6 hours and warded with catheter in situ. There was no documentation in the notes about position change in labour, pads being changed or purpose T being completed. As a result, there is little evidence to support good practice in this case. ☹️ - Always ensure Purpose-T and frequent position changes are documented once limited mobility occurs. Women should be kept dry and 0000 should be changed regularly for the prevention of moisture damage and for women's comfort. Women should also be prompted to read the patient facing posters in the clinical areas informing them of how to avoid harm with frequent position changes to help themselves avoid skin damage. - Please ensure all reported moisture lesions or pressure areas are photographed by medical photography at the time of reporting and ask the Tissue Viability nurse to attend and grade the area before discharge.
-------------	--

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This important documentation can make all the difference to the outcome for the women under DOC.

- SAMS incidents:** An incident of inappropriate SAMS medication was identified in May where a patient had taken ibuprofen too early following administration of PR diclofenac in theatre. On investigation it was clear that diclofenac was not prescribed on the drug chart or on the anaesthetic chart as a record of what was administered in theatre. Although this was an anaesthetic error, as Midwives commencing SAMS on CDS can ensure that all drugs including those given in theatre are accounted for and reflected in the SAMS paperwork before going to ward 20. The learning from this incident has been fed back to the anaesthetic team ☺️
- PPH incidents:** Obs Cymru charts are not always being completed in full ~~0000~~ is the post events section following a PPH. Can we all ensure this document is completed in full, as this document when completed properly will evidence all appropriate aspects of PPH management in that incident, providing assurance that the care provided during that emergency has been appropriate and safe.
- Perinatal team working:** The ASTRA project is aiming to prevent the separation of mothers and babies. Reported incident where ASTRA observations were not performed after the first hour on CDS: The missed ASTRA observations in both incidents reported were due to the Midwife providing essential care in theatre at the point where midwives would take over the ASTRA observations. In these cases the Midwifery staff physically could not perform the ongoing observations on the baby in LDU, and assumed the neonatal staff were recording the observations. The investigation identified learning for both Midwives and Neonates.

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If you are unable to do ASTRA observations due to caring for the mother away from the baby, please inform the coordinator who can liaise with neonates or will find help to support you while you ~~000000~~ the mother's care.

As part of the investigation Midwives were asked for their feedback and incidental learning became apparent. The Midwives stated they were concerned that the handover from the neonatal staff for ASTRA observations was not always effective. Their experience was that ~~000000~~ performed by the neonates in the hour of ASTRA are not being documented on the NEWTS chart but recorded on the proforma which is then returned to NICU. This means that the condition of the baby is not always clear and a trend can't easily be identified on NEWTS. They also said it is sometimes not made clear to the Midwife when the neonatal Doctor or Nurse will be returning to perform further reviews.

This staff feedback was fed back to the Neonatal team via the Neonatal Risk Nurse and ANNP. The agreed process is for neonatal staff to complete the observations on both the proforma and the NEWTS chart for completeness and to ensure a true picture on NEWTS is captured. The flow chart for ASTRA is also now on display in the clinical area to help clarify the process and aid effective communication between the teams

- Late Fetal Loss with signs of life incident:** In May a baby was born on CDS at 21-week gestation with signs of life. who sadly passed away shortly after. Unfortunately, the Midwife did not ask the Obstetric doctor to attend when signs of life were noted nor to confirm the death. In such cases a Death needs to be present to record this information for the birth and death certificate. This is required regardless of gestation if signs of life are apparent at birth. As no Doctor was involved the family then had to wait for the case to be investigated by the medical examiner's office and Coroner before being issued with the certificates. Please can all staff be reminded of this important aspect

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Neonatal Risky Business July 2026 (June Data)



✓ Bags containing heparin is now a now stored in a separate box clearly marked.



Medication Safety Reminders :

- ✓ Complete and document thorough IV fluid checks at every nursing handover.
- ✓ Always verify prescribed medications and infusions against the prescription chart before preparing and administering them.
- ✓ Do not rely on verbal prompts or assumptions when administering medication.
- ✓ Remember, if it's not documented, it's considered not done. Don't forget the final step: sign the drug chart after administering the medication..

A few reminders regarding documentation:

- ✓ Ensure that all specialist reviews in Badger Net include a documented management plan, so the midwifery team is aware the plan.
- ✓ Use standardised electronic and verbal handover processes for all babies requiring ongoing neonatal review outside of the neonatal unit. All babies needing review (outside the unit) should be included on the PNW handover list.
- ✓ Ensure clear and complete Badger Net documentation when babies are transferred from the NICU to the ward 5/postnatal ward.





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of care when dealing with these difficult cases to avoid any delays for the family.

- ATAIN incident learning:** Escalation of concerns to senior neonatologist: A baby born on CDS had a low temperature recorded from 1 hour after birth and developed increased respirations. The baby had received 4 separate reviews by an SHO over a period of 6 hours with the baby's temp not being over 36.4. Although good practice was observed for thermoregulation by the Midwives, consideration was not made by the staff or the neonatal SHO to escalate for a senior review as the baby's condition deteriorated. This case highlights that importance of jump calling, and that jump calling for a senior review is as important for neonatal care as it is for the mother.
- The agreed MDT learning from this incident: if a plan has been put in place by a junior Doctor but has not resulted in improvement in the baby's condition, consideration should be made to escalate concerns and ask for a senior doctor review to appropriately and professionally challenge plans of care.

Ward 19 Antenatal

- Lack of adequate pain relief incident and formal complaint:** The health board recently settled a case under redress for pain and suffering for a woman who was not examined in a timely manor on the antenatal ward to confirm that labour was established. This caused a delay in providing adequate pain relief to that woman and we were found in breach of duty and a qualifying liability was accepted.
- The agreed learning is for all women to be offered a vaginal examination when they experience increasing pain and discomfort, especially when undergoing IOL, so that active labour can be diagnosed and adequate analgesia provided in a timely manner. Effective analgesia (only paracetamol was offered on ward 19) should have been offered both on the antenatal ward and on transfer of the patient to the labour ward. On

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labour ward the patient was given ~~000000~~ to use for pain relief whilst she requested an epidural. The Midwife documented that she advised the patient that an epidural would not be effective in managing her pain due to the length of time it would take to become effective. However, the Midwife should have arranged for an Anaesthetist to attend to the patient for them to commence the process of administering her pain relief of choice irrespective of her labour stage or imminence of birth.

Can all staff be aware that if a woman requests pain relief, then the appropriate steps need to be taken to provide the pain relief of choice, regardless of how long that pain relief may take to administer.

- High acuity incident:** If there are no beds on ward 19 for planned Induction of labour admissions, please ensure both fetal and maternal wellbeing is fully assessed, including discussions with the Obstetric team. Ask about fetal movements and if any DFM is reported then an antenatal cCTG must be performed before rearranging date and time to return for planned IOL. If no capacity on ward 19 or CDS then staff need to liaise with ADAU for a monitoring to safely rearranging the induction.

Antenatal Clinic

- Medicines management:** In June two incidents were reported where the wrong pre-meds had been dispensed to two patients from ANC. Please note that if 1000 are dispensed then two registered Midwives need to check the medication and sign these out as being dispensed to the correct patients in the book supplied. The book will then be audited to ensure compliance as per medicines management SOP.
- Missed Antenatal care:** If a care plan is changed following a consultant clinic appointment can

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the doctor ensure that this is communicated to the ANC midwives so that the change can be followed up correctly.

An incident where a plan for serial scans was changed by an Obstetrician to SFH measurements with daily BP checks was not put in place and care was missed as a result. The investigation revealed that the ANC midwives were not informed following the consultation, so did not contact NPT to update the community daily calls to include daily BP checks and inform the community midwives to revert to SFH measurements. This woman was not seen from 28 weeks until over 37 weeks with no BP checks and no SFH surveillance. No harm was caused but this case highlights the importance of effective team work and communication for safe follow up care planning.

Antenatal Assessment Unit

- ALTERED FETAL MOVEMENTS & ASSESSMENT OF FETAL GROWTH**
- Please ensure that you follow the list of investigations within the BSOTS investigation card for every mother presenting with altered fetal movements. For clarification, should a mother present with altered fetal movements during her pregnancy, she should receive a full antenatal check which should include:
- A review of the appropriateness of the method of assessing fetal growth (i.e. fundal height measurements or serial growth USS)
- Offer abdominal palpation for all women regardless of method of growth assessment

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HIE rates

Morbidity – HIE

ALERT

HIE remains a rare but high-severity outcome requiring detailed review of every case and continued system vigilance. One case was reported in July and remains under investigation.

ADVISE

Robust rapid review, investigation and learning processes are in place, supported by ongoing SPC monitoring and multidisciplinary governance oversight.

ASSURE

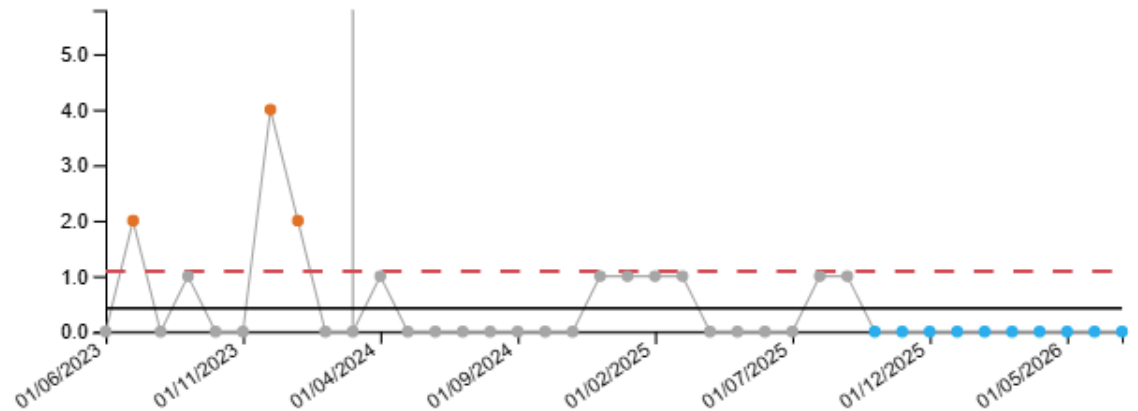
The service has demonstrated sustained improvement, with a rolling 12-month moderate/severe HIE rate of 0.94/1,000 births and evidence of statistically significant positive variation.

Inborn Maternity and Neonatal Term HIE incidences – 2026

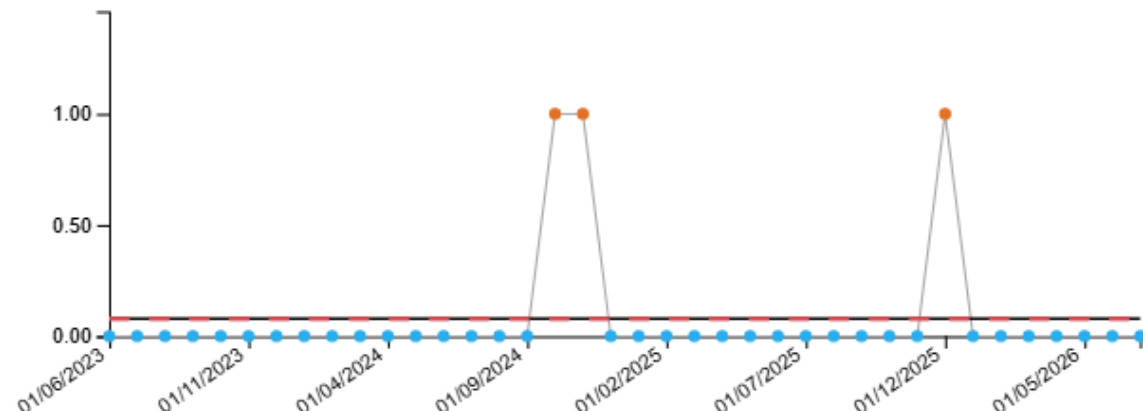
Case	Place of birth	Gestation	MRI findings	Avoidable Yes/No	Outcome	Grading of HIE
1	Singleton	37+1	There is a solitary subcentimetre area of signal change in the right peritrigonal white matter. This exhibits restricted diffusion and is likely to represent an area of acute/subacute ischaemia. No other significant intraparenchymal abnormality. In particular, the deep grey nuclei, splenium and brainstem are normal	Under review	Rapid review regarding discussion of whether criteria met for cooling.	As undergone therapeutic cooling may need regrading but currently graded as a 1

HIE – Trends 12 months – July 2026

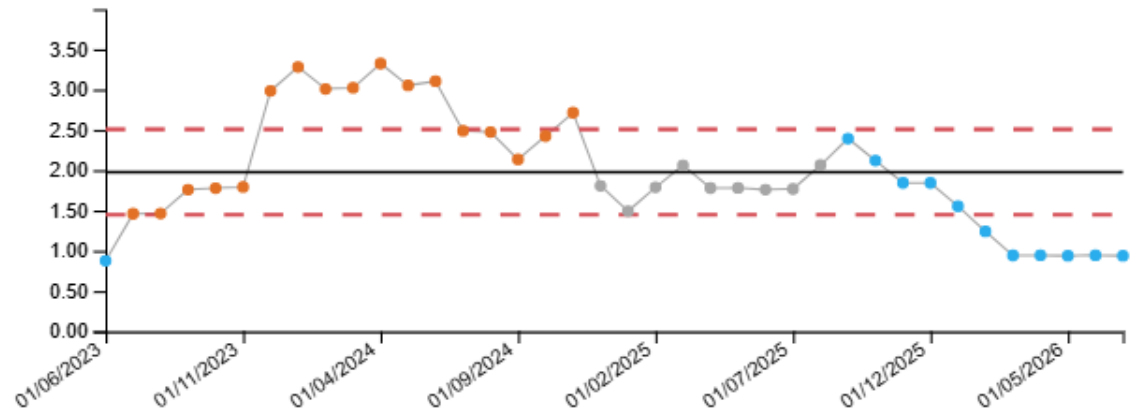
Total HIE Grade 2



Total HIE Grade 3



HIE Grades 2 & 3 Rolling 12 month average per 1000 births



The 2025 HIE rate is 1.68/1000 births.

One mortality in December 2025 – HIE Grade 3. Reported as NRI.
No HIE IN 2026

As seen there are 8 plots below centre line of 2.1 therefore showing a SHIFT in data. This is a strong example of Non random variation.

Monitoring will continue

HIE 2 and 3 rolling 12 month average – 0.94/1000 births



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

Mortality



Un Bae Ar y Cyd
One Bay Way

Perinatal Mortality

ALERT

Mortality events remain rare but significant. External review capacity and changes to network mortality processes continue to present challenges to timely system-wide assurance.

ADVISE

Mortality governance arrangements are being strengthened through PMRT oversight, multidisciplinary review, revised review processes and exploration of alternative external assurance mechanisms.

One Neonatal death in July 2026. Known fetal anomalies in twin pregnancy, for palliative care at birth.

ASSURE

All mortality cases are subject to structured review and governance oversight, with clear commitment to organisational learning, family involvement and continuous improvement.

Maternity Mortality Data for 2026 - Stillbirth

Case	NND/SB	Date	Gestation	Ethnicity	Weight/BWC	Age of death	Grading of care
103191	Stillbirth	31/03/26	28+4	Pakistani/Welsh	840g/0.2	Stillbirth	C
104604	Stillbirth	21/04/26	37+3	White/Welsh	3600g/96	Stillbirth	A
107037	Stillbirth	26/05/26	37+6	White/Welsh	2000g/0.1	Stillbirth	B

Grading of care

A - no issues with care identified up to the point that the baby was confirmed to have died

B - identified care issues which was considered would have made no difference to the outcome for baby.

C – identified care issues which they considered would have made a difference to the outcome for the baby

D – identified care issues which they considered were likely to have made a difference to the outcome.

*Maternity and Neonatal care is graded separately.

Neonatal Mortality data for 2026

Case	NND	Month	Gestation	Ethnicity	Weight/ BWC	Age of death	Included in SBUHB MBRRACE report	Locally reviewed and presented	Coroners inquest	Grading of Care
1	NND/LW	Feb	29+1	White British	380 grams	0	Yes	Presented locally May 7th	No	B
2	NND	March	32+4	White British	1677 grams	15 hours	Yes	Presented locally May 7th	Yes	B (Coroner's inquest)
3	NND born in Cwm Taf	May	40+6	White	3480 grams		No	Waiting for local and joint review date	No	TBC
4	NND Born in HDUHB	June	39+0	White Other	3740 grams	45 hours	No	Waiting date for local and joint review.	No	TBC
5	NND	July	31+3	Indian	945 grams	0	Yes – congenital anomaly	Waiting to be allocated	No	TBC

Grading of care
A - no issues with care identified up to the point that the baby was confirmed to have died
B - identified care issues which was considered would have made no difference to the outcome for baby.
C – identified care issues which they considered would have made a different to the outcome for the baby
D – identified care issues which they considered were likely to have made a difference to the outcome.

*Maternity and Neonatal care is graded separately.

Died Elsewhere

Case	NND	Month	Gestation	Ethnicity	Weight/ BWC	Age of death	Included in SBUHB MBRRACE report	Locally reviewed and presented	Coroners inquest	Grading of Care
1	NND	March	26+3	Indian	350 grams	45+6	No > 28 days	July 4th – postponed awaiting future date	No	TBC
2	NND born in Cwm Taf	June	22+5	Black Other	350 grams	34+5	No > 28 days	Waiting date for local and joint review.	No	TBC
3	NND	March	26+3	Black African	450 grams	28+5	No > 28 days	Waiting date for local and joint review.	No	TBC

Inborn

Outborn

PMRT position - Information correct to 5/8/2026

2 open cases in Perinatal Surveillance – 1 sitting with Cwm Taf HB and other is a recent case.

12 open reports in PMRT -

2024	2	1 x Report written – waiting response for care provided by Morriston hospital (Q&S team) maternal death
		1 x awaiting WAST/EMRTS resus paperwork to complete
2025	6	2 x pre published
		2 awaiting external review report/PM
		1 x recently had ER/PM needs grading of care
		1 x sitting with GGH to complete details
2026	4	1 x waiting internal review
		1 x to be presented locally in maternity
		1 x sent back to CTM for input, local data inputted.
		1 x to be presented and completed locally



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Swansea Bay University
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MatNeo Workstreams National Report Phased prioritisation - Quarterly Update



Un Bae Ar y Cyd
One Bay Way

MatNeo Workstream Overview: Position, Progress & Risk

MatNeo-led support across priority national workstreams

STATUS	WORKSTREAM	PROGRESS	RISK	FOCUS
 ADVISE	Call for Concern	 Escalated workstream; improvement plan in place and timeline on track	 Sustained concern requiring oversight	 Deliver action plan, monitor impact
 ADVISE	BSOTS	 Digital audit introduced mid-month; early dataset available	 Reduced 15min compliance (77%) indicates data quality gaps compared to paper audit	 Validate dataset; embed digital process; improve timeliness & recording
 ADVISE	MUSA	 SOP in development; printing costs and resources being progressed	 Governance and rollout not fully embedded	 Strengthen governance; continue education; digital rollout
 ADVISE	Open Access	 Registrations increasing; monitoring post BadgerNet go-live	 Variation in access and pathway use	 Standardise pathway; improve data and service user engagement
 ADVISE	Smoking in Pregnancy	 Referral pathway moved to BadgerNet; activity significantly reduced	 Loss of early intervention; very low referrals; workforce gaps	 Urgent pathway review; restore early contact; workforce support
 ASSURE	Birth in Right Place	 Appropriate birth setting established; ongoing review of transfers	 Variation under review	 Maintain MDT oversight and pathway alignment
 ASSURE	MEWS/NEWTTS2	 Ongoing assurance; compliance maintained	 Escalation consistency risks	 Maintain compliance; transition to digital system



Alert status reflects current position, progress and risk profile.



AID
Immediate action and support required

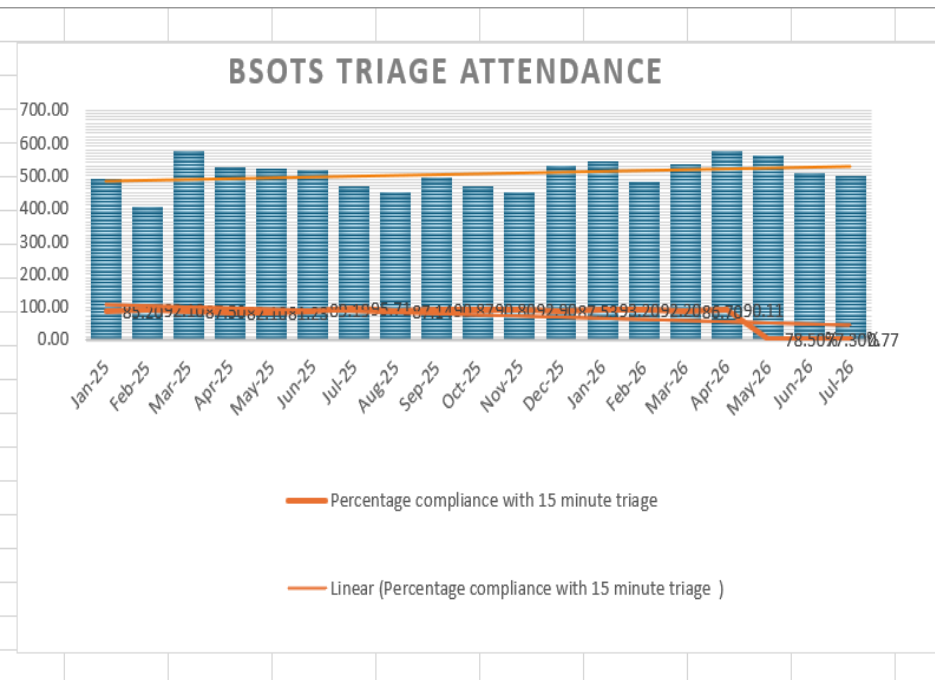


ADVISE
Monitor and manage



ASSURE
On track and controlled

Month	Number of women attended	Percentage compliance with 15 minute triage
Jan-25	492	85.20
Feb-25	405	92.10
Mar-25	574	87.50
Apr-25	525	82.10
May-25	521	81.23
Jun-25	518	89.19
Jul-25	466	95.71
Aug-25	450	87.14
Sep-25	493	90.87
Oct-25	466	90.80
Nov-25	450	92.90
Dec-25	530	87.53
Jan-26	546	93.20
Feb-26	483	92.20
Mar-26	534	86.70
Apr-26	575	90.11
May-26	563	78.50%
Jun-26	507	77.30%
Jul-26	500	0.77



- Go Live 19th May
- BSOTS BadgerNet Data Reports from May 20th onwards
- May 2026 was 2 system merge
- June first full month reported on BadgerNet
- Bespoke Data reporting request in process

Ongoing dataset will reflect a new digital audit approach; therefore findings should be interpreted with caution while data quality and completeness are reviewed

Triage (BSOTS) Report

 Set Parameters

Selected Parameters:

Care Locations

Admit Date From

Admit Date To

Singleton Hospital - Maternity (Swansea) 01 Jul 26 00:00 31 Jul 26 23:59

Reason for Attending

	Total	Abdominal Pain	Antenatal Bleeding	Hypertension	(P)PROM-Ruptured Membranes	Reduced Fetal Movements	Suspected Labour	Unwell or other	Postnatal Event	Not Recorded
Attendances	500	53	40	27	53	171	61	61	32	2
Women	360	46	34	23	48	148	53	57	27	2

Initial Triage Assessment

Attendances	Initial assessment within 15 mins	Meets target %	Initial assessment not within 15 mins	Initial assessment time not recorded	Green	Yellow	Orange	Red	Level of Urgency Not Recorded
500	383	76.6	115	2	66	374	58	1	1

Ongoing Midwifery Care

Level of Urgency	Attendances	Commenced within the allocated time	% Meets Target	Not commenced within the allocated time	Unable to calculate compliance
Green (4 hours)	66	59	89.4	7	0
Yellow (1 hour)	374	308	82.4	64	2
Orange (15 mins)	58	45	77.6	12	1
Not recorded	1	0	0	0	1

Ongoing Medical Care

[illegible]



CALL4CONCERN (C4C)

Maternity Services Soft Launch Update



Empowering patients, families and carers to raise concerns and access timely clinical review.

SINCE LAUNCH



2

Calls Received

1

General Site Call

Redirected to appropriate complaints process

2

Maternity Test Escalation

- ✓ Valid acute deterioration identified
- ✓ Escalation pathway tested successfully

System tested and operational

EXISTING ASSURANCE

C4C is embedded within our current safety and quality processes.



MEWS Reporting



Patient Wellness Score (PWS)



NEWTTTS2 Monitoring



AMAT Assurance Audits



Safety Huddles



Handover Reviews



Patient Wellbeing Checks

"Embedded, not added" – avoiding additional audit burden

EDUCATION & AWARENESS



2-Minute Handover Training

QR Code Learning Package

Delivered through:

- ✓ Handover
- ✓ Cascade Teaching
- ✓ Safety Huddles
- ✓ Staff Briefings



Key message:

Ask • Listen • Document • Escalate

ASSURANCE SNAPSHOT SURVEY

1

Were all Call4Concern Tier 2 escalations addressed during this shift?

☐ Yes ☐ No ☐ N/A

2

How many patient/family concerns were raised and addressed during this shift?



Demonstrates patient voice



Provides real-time assurance



Supports compliance



Avoids additional audit burden

CURRENT & FUTURE WORK



Continue monitoring through MEWS, PWS and NEWTTTS2



National Neonatal Observation Chart development



Discussion at next ADPIN meeting



Ongoing Health Board awareness campaign



KEY MESSAGE

CALL4CONCERN

Giving patients a voice in escalating deterioration concerns



Soft Launch Complete



Escalation Pathway Tested



Education Underway



Assurance Embedded



Further Development Ongoing



LISTEN • RECOGNISE • ESCALATE • ACT





CALL CENTER PERFORMANCE REPORT

Executive Summary & Call Analysis



EXECUTIVE SUMMARY



TOTAL CALLS

5,507



ANSWERED

3,420

62.10%



BUSY / NO ANSWER

2,055

37.30%



UNAVAILABLE / OTHER

30

0.50%



FORWARDED
(ABM-CUBE-MORR)

110

2.00%



TRANSFER COUNT

Not explicitly
recorded

(2,455 internal extension-
to-extension calls)



AVERAGE CALLS
PER HOUR (MONTH)

7.65



AVERAGE DURATION
PER CALL

2m 20s

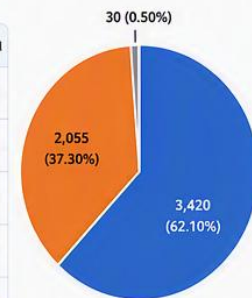


TOTAL TALK TIME

201.5h

CALL OUTCOME BREAKDOWN

Outcome	Total Calls	% of Total
Answered (A)	3,420	62.10%
Busy / No Answer (B)	2,055	37.30%
Unavailable / Other (U)	30	0.50%
Blank / Unknown	2	0.10%
TOTAL RECORDS	5,507	100%



■ Answered (A) ■ Busy / No Answer (B)
■ Unavailable / Other (U) ■ Blank / Unknown



CALL DURATION ANALYSIS

Duration Band	Calls	% of Answered Calls
0-30 seconds	942	27.50%
31-59 seconds	671	19.60%
1-2 minutes	755	22.00%
2-3 minutes	403	11.80%
3-4 minutes	260	7.60%
4-5 minutes	151	4.40%
5-10 minutes	211	6.20%
10+ minutes	25	0.70%
Total	3,420	100%



AVERAGE CALLS
PER HOUR (MONTH)

7.65



AVERAGE DURATION
PER CALL

2m 20s

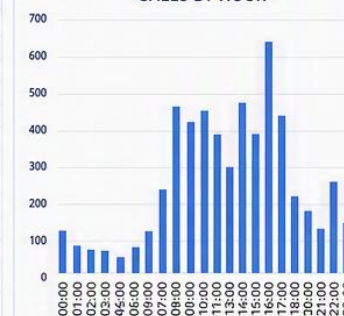


CALLS BY HOUR OF DAY

Hour (24h)	Calls
00:00-00:59	95
01:00-01:59	69
02:00-02:59	64
03:00-03:59	57
04:00-04:59	56
05:00-05:59	81
06:00-06:59	89
07:00-07:59	221
08:00-08:59	430
09:00-09:59	360
10:00-10:59	411
11:00-11:59	387
12:00-12:59	272
13:00-13:59	430
14:00-14:59	368
15:00-15:59	632
16:00-16:59	398
17:00-17:59	202
18:00-18:59	195
19:00-19:59	140
20:00-20:59	234
21:00-21:59	125
22:00-22:59	101
23:00-23:59	88

TOTAL CALLS
5,507

CALLS BY HOUR



PEAK PERIODS (BY NUMBER OF CALLS)

1

15:00 hour
632 calls
(11.5% of all records)

2

08:00 hour
430 calls

3

13:00 hour
430 calls

4

10:00 hour
411 calls

5

16:00 hour
398 calls



ADDITIONAL NOTE

Transfer count: Not explicitly recorded in this report;
2,455 calls were internal extension-to-extension calls.

Plan:

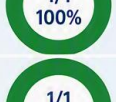
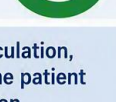
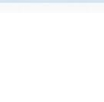
Figures escalated to Abbie Morris
WAST working on National Maternity Line

Single Point of Access Action Plan

Action	By Whom	By When
Update SBUHB Website to remove all other telephone numbers	Abigail Morris	COMPLETE
Update BadgerNet Messaging to explain when patients will be contacted antenatally to reduce calls. Original message stated 'will be called in 1-2 weeks' changed to 'will be called depending on gestation'	Becky Newton Williams	COMPLETE
Second round of Staff Engagement to be completed	Cath Harris & Abigail Morris	COMPLETE
Task & Finish (T&F) Group to be established	Cath Harris	August 26
Digital to produce monthly reporting and to be presented at T&F	Becky Newton Williams	As per T&F
Consider Communication with Womens and Families around 'RIGHT PLACE TO CALL'	ALL	As per T&F

10 set NEWTTS2

July

	Correct chart used	10 (100%)	
	Calculated correctly	10 (100%)	
	Was the frequency of observations increased as per local guidance	3 (30%) NO 7 (70%) N/A	
	Did the patient meet trigger for escalation	1 (10%) YES 9 (90%) NO	
	If so was the patient escalated as per guidance	1 (100%) YES	
	Was there a response	1 (100%) YES	
	If so was this appropriate and timely	1 (100%) YES	
	100% compliance with chart selection, score calculation, escalation, response and timeliness standards. One patient met escalation criteria and all aspects of escalation management were compliant.		

NEWTTS2

BAU from July 2026

Audit plan action:

Business as usual to be put on AMAT (awaiting)

ACUTE DETERIORATION AUDIT

Early Warning Score (EWS) Chart Review



JULY 2026



LABOUR WARD



100%

Overall Compliance



4/4 sets compliant

WARD 19 & AAU



92.3%

Overall Compliance



12/13 criteria met

WARD 20



100%

Overall Compliance



4/4 sets compliant

OVERALL (ALL AREAS)



96.2%

Overall Compliance



25/26 criteria met

KEY ASSURANCE INDICATORS

AUDIT CRITERIA	LABOUR WARD	WARD 19 & AAU	WARD 20	OVERALL (ALL AREAS)
EWS calculated correctly	✓ 100%	✓ 100%	✓ 100%	✓ 100%
Full set of observations recorded	✓ 100%	✓ 100%	✓ 100%	✓ 100%
Vital signs/EWS repeated in a timely manner	✓ 100%	✓ 92.3%	✓ 100%	✓ 96.2%
Patient escalated appropriately	✓ 100%	✓ 100%	✓ 100%	✓ 100%
Escalation response time met	✓ 100%	✓ 100%	✓ 100%	✓ 100%
Sepsis screening completed appropriately	✓ 100%	✓ 100%	✓ 100%	✓ 100%
Patient Wellness Score (PWS) recorded twice in 24 hours	✓ 100%	✓ 100%	✓ 100%	✓ 100%



PWS COMPLIANCE

100% compliance across all areas

100% of patient records had a Patient Wellness Score (PWS) recorded at least twice in the last 24 hours.



METHODOLOGY CHANGE

CURRENT AUDIT

- 4 records per month per clinical area
- Areas reported separately

PREVIOUS AUDIT (prior to May 2026)

- 10 records per area
- 30 records combined across Labour Ward, Ward 19 & Ward 20

ACTION:

Produce now annual figures for next PA Meeting
Awaiting Bespoke BN data reports

MUSA Update

Vic Owens **Cons MW**

Helen Etheridge, Julie Jones & Hannah Gardner



MUSA STATUS:
AMBER

Sustained concern
requiring oversight

Key Milestones	Progress / Comments
1. Philosophy of Care – For Each MU	Approved. Printing costs are currently being sourced/obtained for display. FMU already has Philosophy in place.
2. Overarching Operational Policy for MU's in SBUHB	SOP currently in development/review and out for comment.
3. Transfer Touch Points	Touch points introduced for women transferring from FMU or BBU. Contact made at 6 weeks postnatally to discuss transfer experience and offer opportunity for feedback. Process commenced October 2024 (n=17).
4. Digital Marketing / Education Resources	Patient Experience Midwife leading workstream (HG). Resources currently being translated into Welsh. Education videos for both AN/PN education are in translation. Social media platforms are being developed to strengthen engagement.
5. Governance / Education / Digital Rollout (NEW)	Improve governance arrangements, continue education programme and progress digital rollout across services.
 Local Huddles	Local huddles occurring every two weeks since 18/06/2025 to review the action plan and provide updates to all staff involved in MUSA work. <i>Lead recently returned from LTS.</i>

WORKSTREAM OVERVIEW

ONGOING



SOP in development; printing costs and resources being progressed

PROGRESS



Escalated workstream; improvement plan in place and timeline on track

RISK



Governance and rollout not fully embedded

FOCUS



Strengthen governance; continue education; digital rollout

STATUS FRAMEWORK (MatNeo)



ALERT

Immediate attention and intervention required.



ADVISE

Progress being made with risks, dependencies or variation requiring active management and oversight.



ASSURE

Delivery on track with risks controlled through routine governance and assurance processes.



NEXT REVIEW: Local huddles every 2 weeks | Next strategic update to MatNeo Workstream via SBUHB PMO

OPEN ACCESS

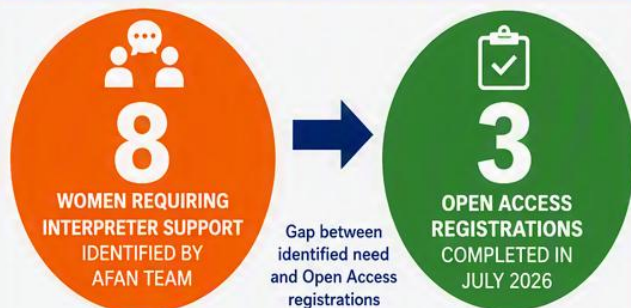
QUALITY & SAFETY UPDATE



JULY 2026



JULY 2026 SNAPSHOT



Afan Team identified 8 women requiring interpreter support during July 2026.¹

REGISTRATION TREND 2026



58

TOTAL REGISTRATIONS
SINCE LAUNCH OF THE INITIATIVE

PROCESS – Pt Exp



Midwife to contact service user accessing Triage via OA, feedback for service development.



9

**SERVICE USERS
CONTACTED**



4

**PROVIDED FEEDBACK
TO DATE**



KEY UPDATES



Afan Team: 8 women identified as requiring interpreter support during July 2026.¹



City data awaited to allow complete comparison across services.



Data collection remains inconsistent across some teams and figures may under-represent need.



No change to **attachment/AAU** attendance data.



CURRENT ACTIONS



SOP to be reviewed at the next Quality & Safety meeting.



Embed **routine identification and registration** of women requiring interpreter support within maternity pathways.



Ensure women requiring interpreter services are considered automatically for **Open Access registration**.



Introduce clear recording processes within the **Triage area** to document **interpreter** requirements and Open Access activity consistently.



BADGERNET UPDATE



BadgerNet went live
May 19th.



Intelligence/comparison
from other HB's to be
explored.

1. Source: Sulla White, Afan Team data – July 2026.



OUR AIM: To ensure every woman with a language need receives timely interpreter support and has automatic access to Open Access services for safe, personalised and equitable maternity care.



Reducing Smoking in Pregnancy

Public Health Midwife back in post;
Figures as requested

Referral month	Total referrals	Referrals still open	Referrals who accepted the service (became a client)	Clients who attended an assessment session	Clients who became 4-week quitters	Client episode closed
April 2026	10	2	8	6		8
May 2026	7	0	7	4		6
June 2026	8	0	8	8		1
Total	25	2	23	18		15

Action:

Need to capture of BadgerNet n-women requesting HMQ service as prior to make sure every women is being contacted in a timely manner (goal would be undertake this prior to Booking Visit)

Perinatal Dashboard

Perinatal Dashboard – update monthly

ALERT

Temporary loss of assurance in some dashboard indicators due to the transition to BadgerNet and ongoing data validation challenges.

ADVISE

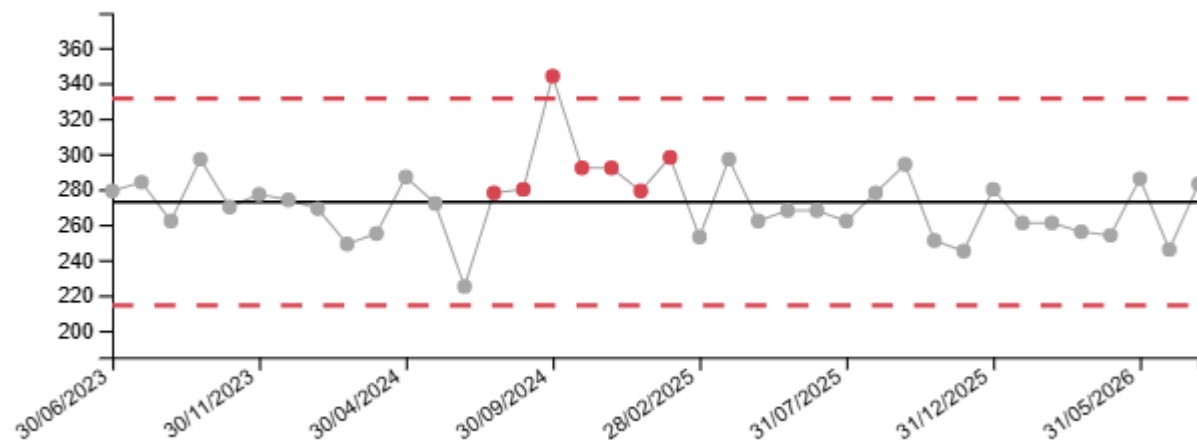
Active recovery plans, data validation processes and digital optimisation work are in place to restore reporting reliability and performance visibility.

ASSURE

Robust governance arrangements remain in place and continue to provide oversight of quality, safety and performance whilst dashboard reporting matures.

Births

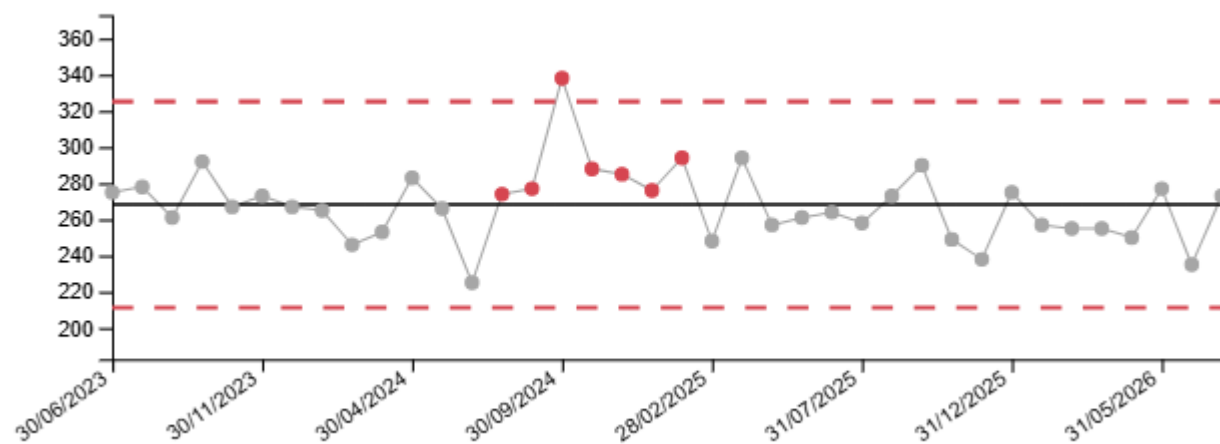
Total Number of Babies Born



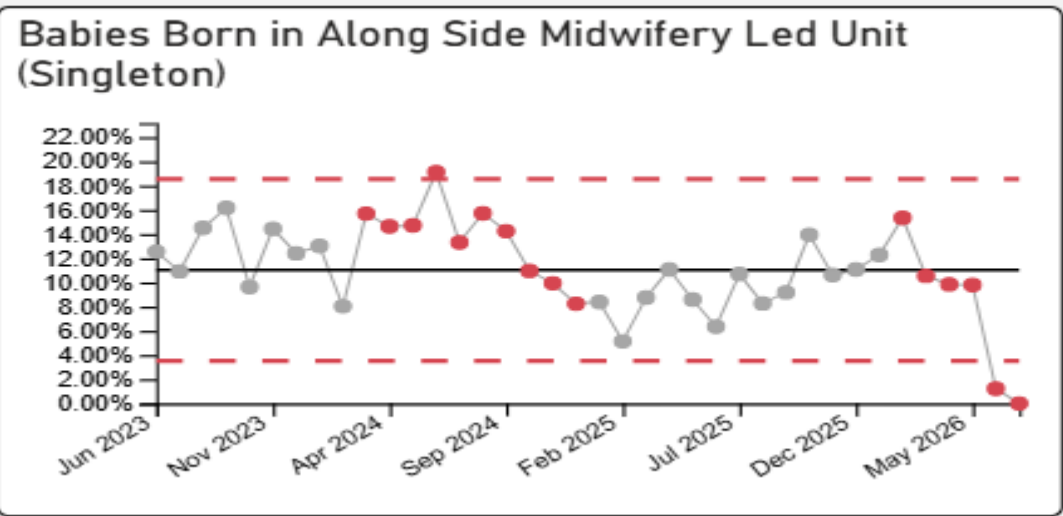
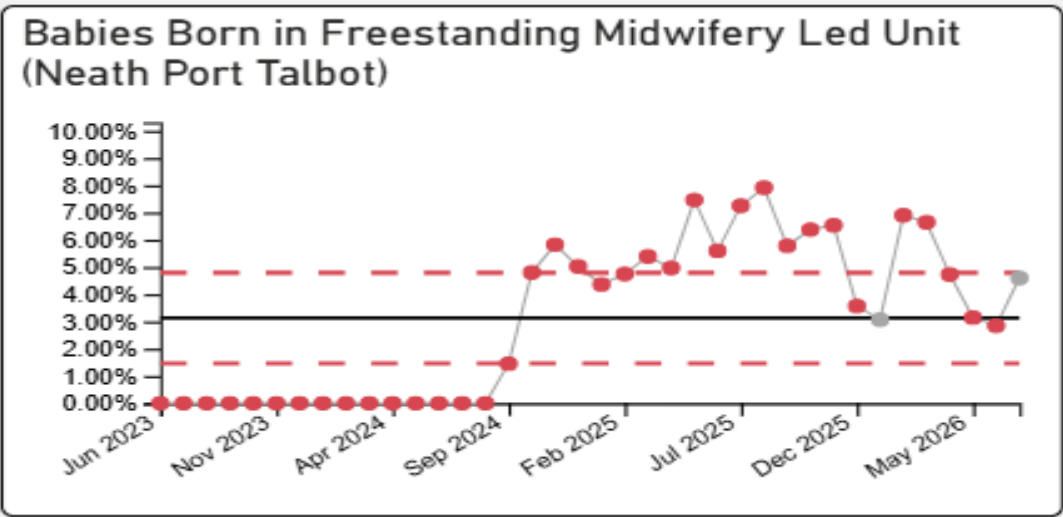
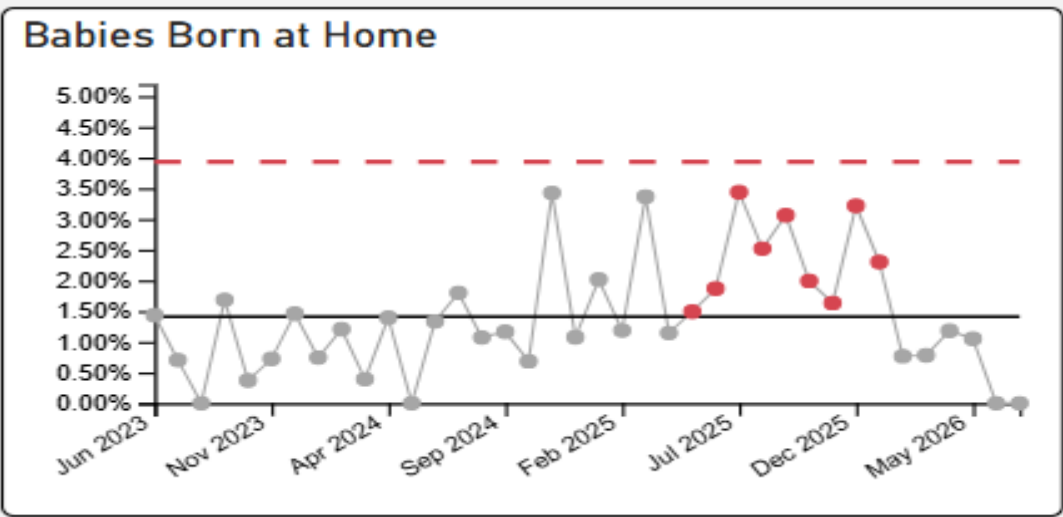
July Birth rate

273 Women gave birth.
283 Babies were born.

Total Number of Women Giving Birth



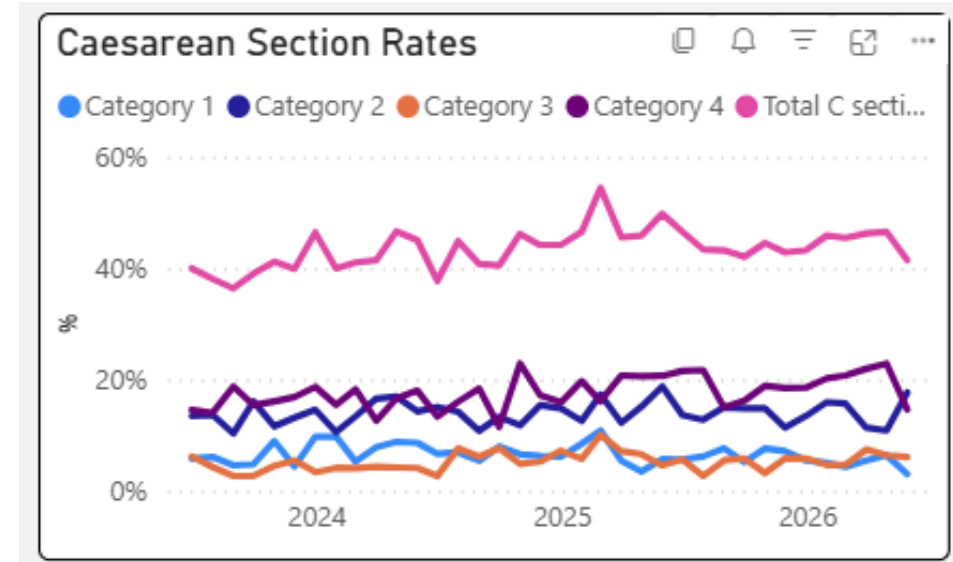
Midwifery Led Births – July 2026



Due to transition to Badgernet EPR – data validation for place of births are incorrect. There is not an inclusion for specific place of birth. Being amended by team to ensure accurate data reflection moving forward in relation to place of birth.

Births by Caesarean Section – June 2026

Unable to provide accurate data due to Badgernet transition.
Meeting arranged with digital to implement mandatory field
due Badgernet digital system to ensure accurate data capture
for Dashboard.



Classification of Caesarean Sections

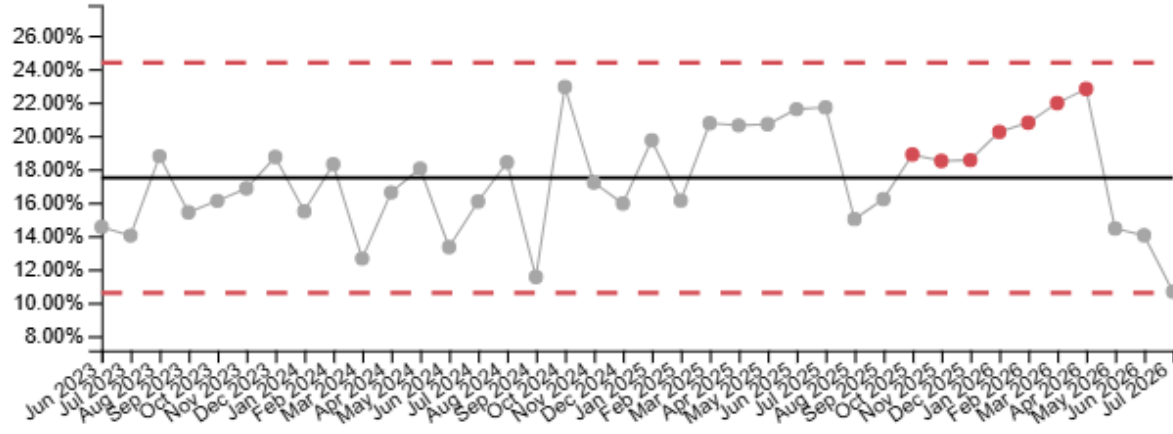
Elective (planned) – Includes Category 3 and 4
Emergency (unplanned) – Includes Category 1 and 2

National trends of CS show increased number of Elective CS with a total CS average rate of 40%.
Higher number of Elective caesarean sections in comparison to Emergency.

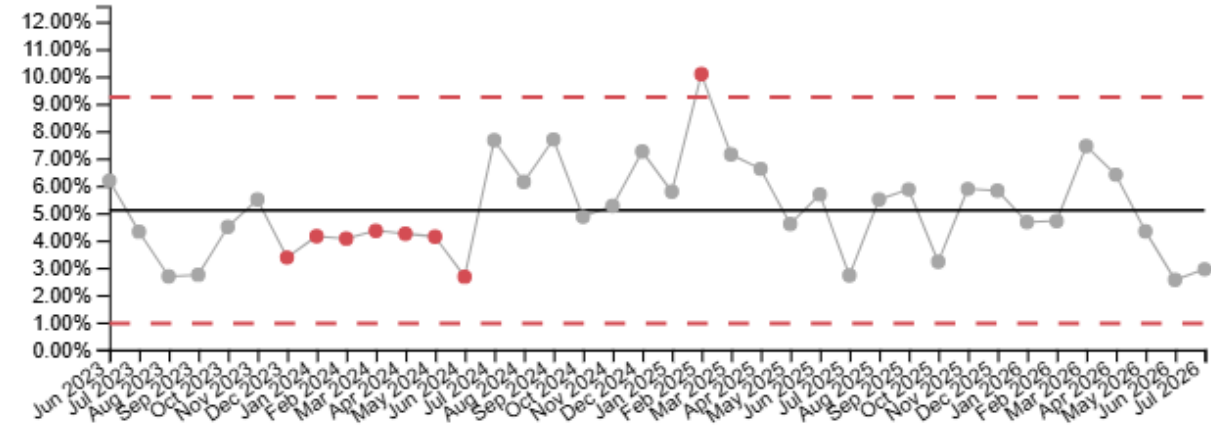
Births by Caesarean Section - 12 months trends

INACCURATE DATA CAPTURE – MAY - JULY

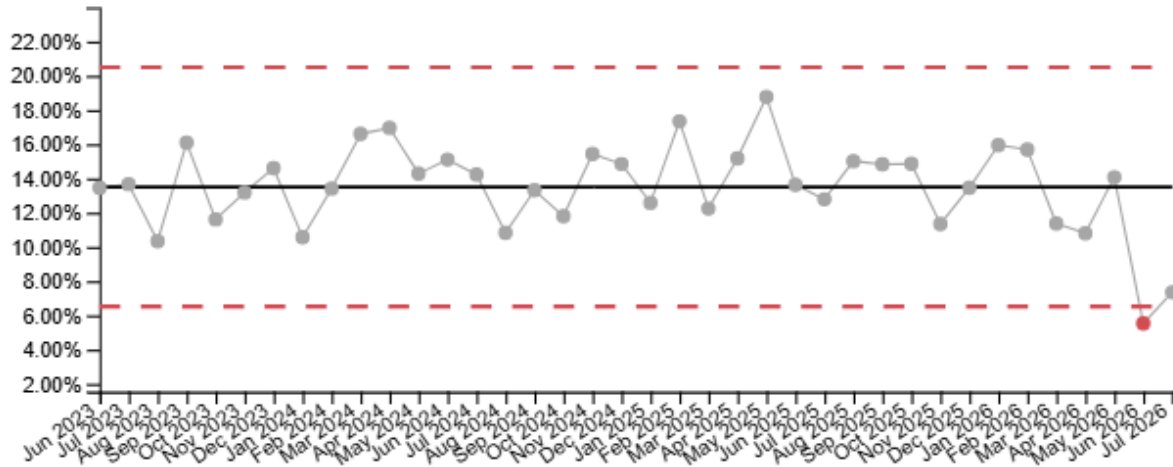
Percentage Elective (Category 4) Caesarean Section



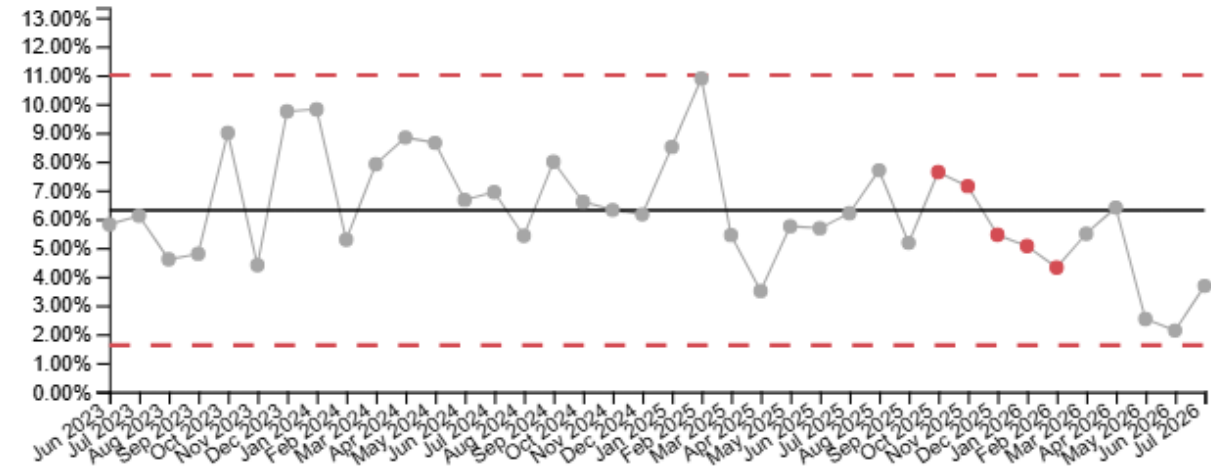
Percentage Emergency (Category 3) Caesarean Section



Percentage Emergency (Category 2) Caesarean Section

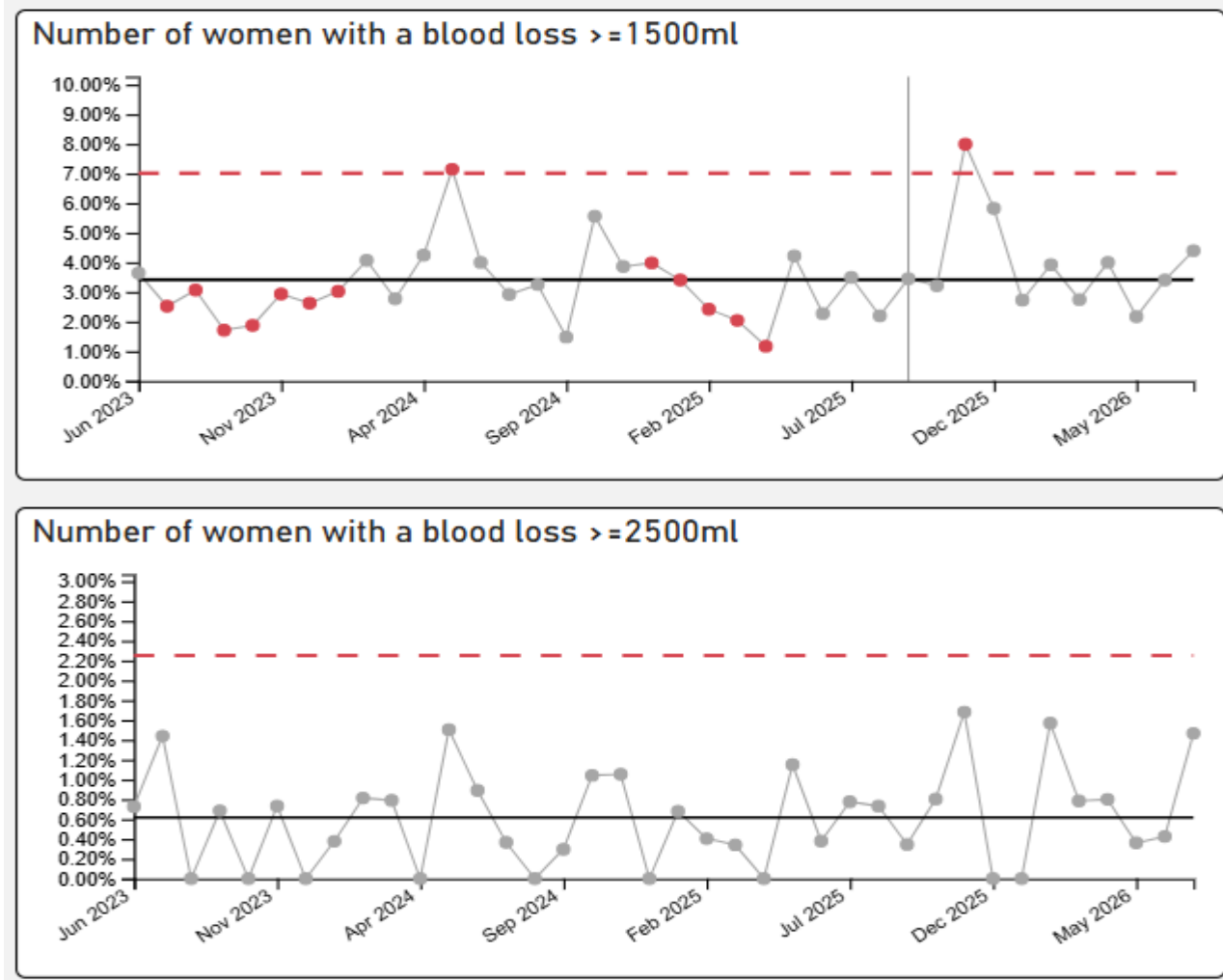


Percentage Emergency (Category 1) Caesarean Section



Maternal Morbidity – 12 month trends

Postpartum Haemorrhage



The NMPA published 2023 data for National benchmarking and reported postpartum haemorrhage incidence as 3.41/1000 births (2.98-3.79). SBUHB rate for postpartum haemorrhage in 2025 was reported as 2.49/1000 births, lower than the National benchmark. This showed a steady reduction from 2024 data, of 3.51/1000 births.

June 2026 – PPH $\geq 1500\text{ml}$ rate is 3.44% and PPH $\geq 2500\text{ml}$ is 0.43%

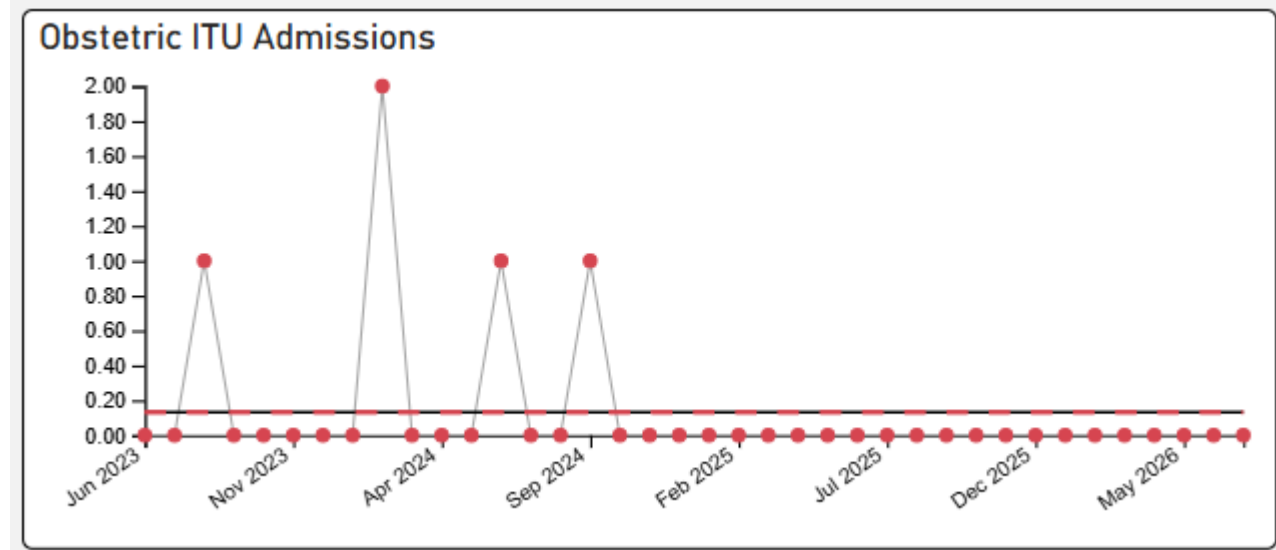


ITU Admissions and Split Site Working

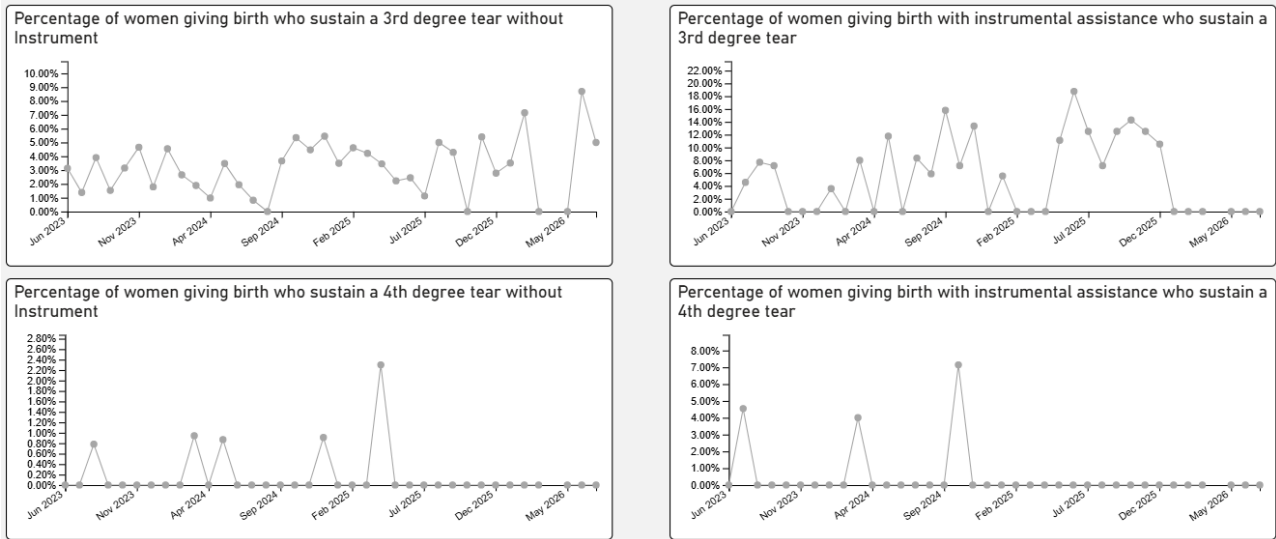
One admission to ITU in April 2026 following postpartum Haemorrhage of 9636mls with hysterectomy. Recovered and transferred back to Maternity services for continued care within 48 hours.

Escalation to digital services has information not on Dashboard

Risk assessment for Split site working completed for escalation to HBRR

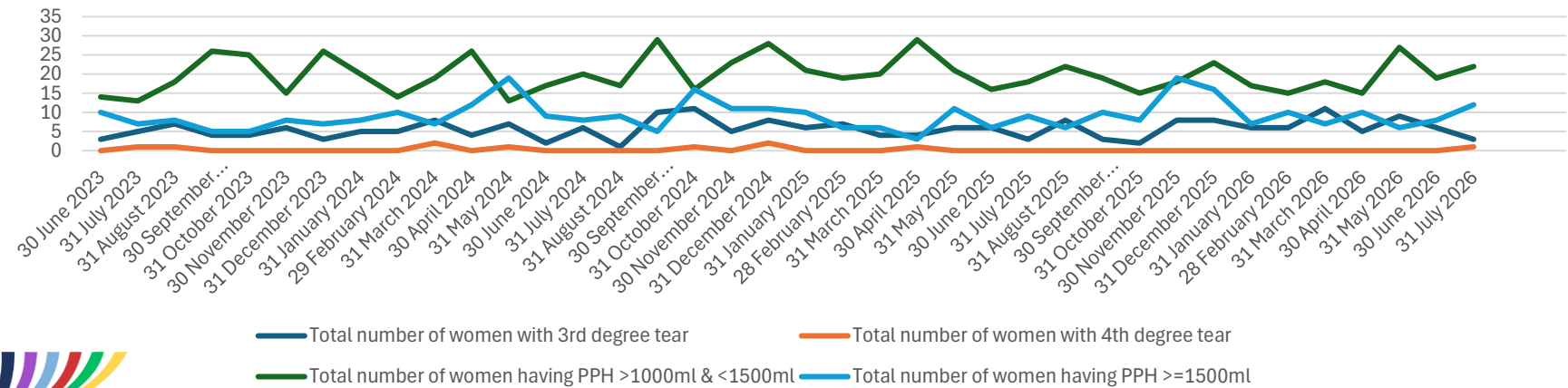


Maternity Triggers – 3rd/4th degree tears – 12 Month Trend - an additional table based on the data has been added whilst the digital solution for annual run chart is being resolved



Clinical studies and dashboards recommend assessing the perinatal tear rate as a percentage against all normal vaginal births. This change has been included within the local dashboard for January 2026 data, therefore reporting percentage of women who sustained a 3rd or 4th perinatal tear against all normal births for SBUHB for the month of January. This has been further disaggregated by mode of birth (vaginal or instrumental)

Women who sustained a 3rd or 4th degree tear and women who had a PPH



ATAIN

ATAIN– update monthly

ALERT

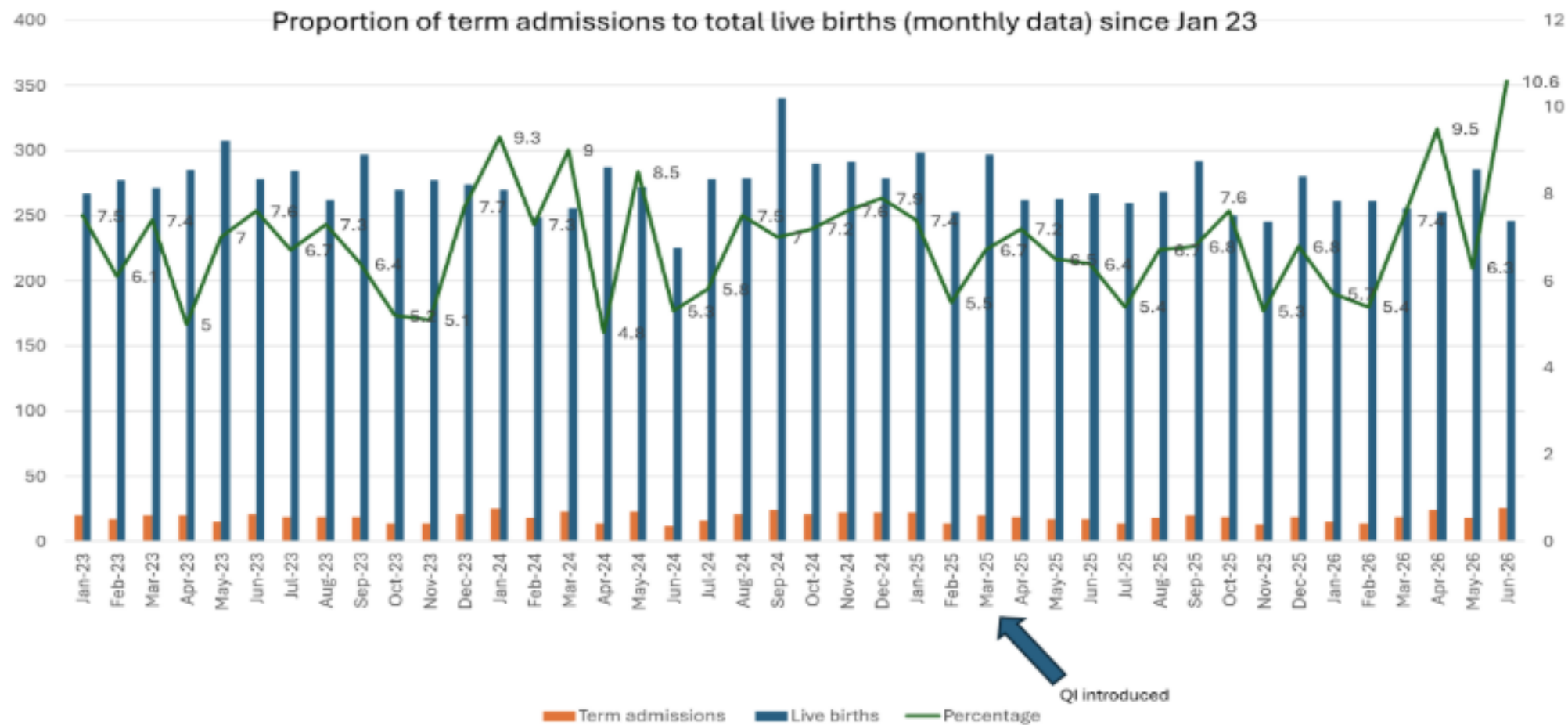
Review timeliness remains the primary risk, with a number of ATAIN cases still awaiting screening and consultant review.

ADVISE

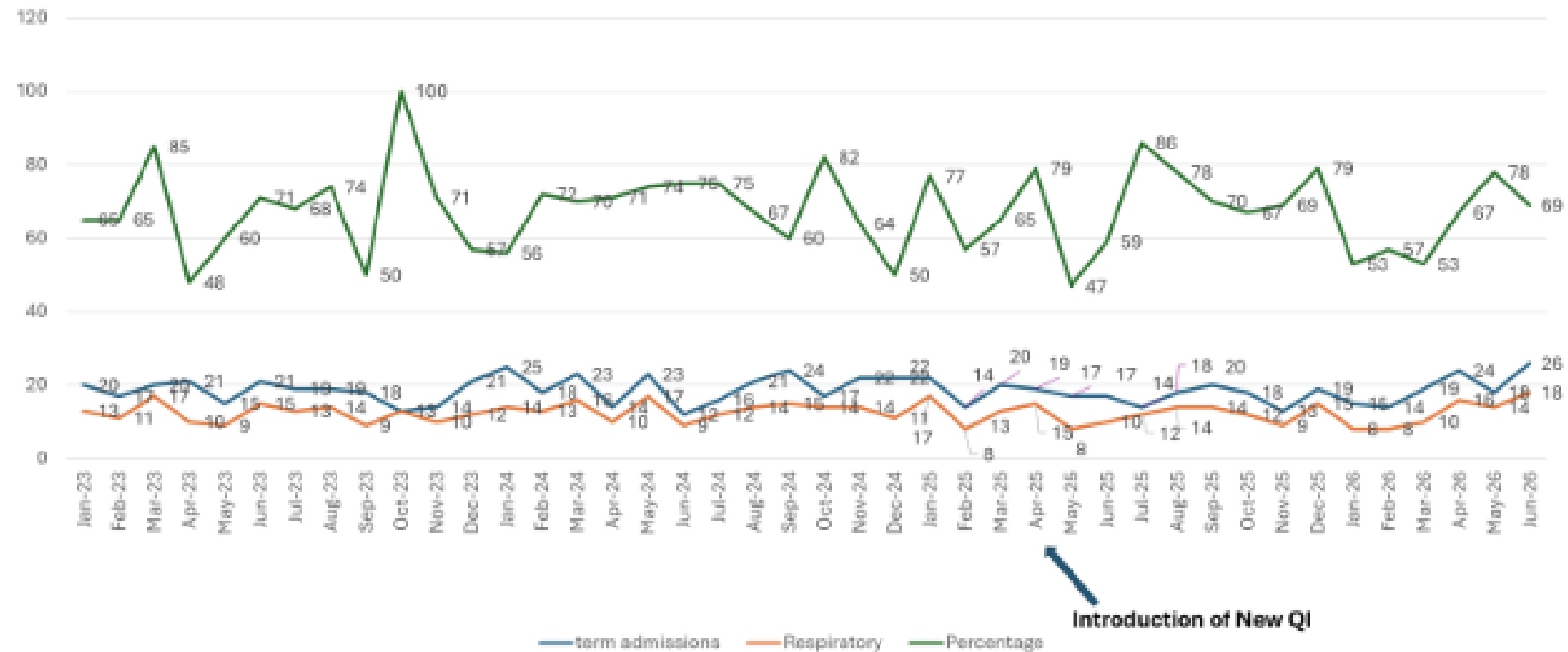
Governance arrangements are established and focused on improving investigation timeliness, review completion and learning identification.

ASSURE

A structured ATAIN surveillance system is now embedded and demonstrating improvements in case management and closure processes.



Term and respiratory admissions – n and percentage



Atain investigation Position (July 2026)

Review Category	Number
Requiring Consultant Review	4
Midwifery Screening	2
Neonatal Screening	6
Awaiting Screening Review	21
Total outstanding	33

A person's hands are visible holding a white rectangular sign. The sign has the words "OPENING SOON" written in a dark, stylized, serif font. The background is a blurred indoor setting with a plant and a window.

OPENING
SOON

QMS – Prototype work stream



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Digital Implementation



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Digital Implementation

ALERT

Reduced specialist digital workforce capacity and ongoing optimisation requirements present a risk to long-term sustainability of digital transformation.

ADVISE

Enhanced governance, business continuity, training and support arrangements remain in place while the service transitions to business as usual.

ASSURE

BadgerNet implementation has been successfully delivered with comprehensive safety controls, multidisciplinary engagement and ongoing quality assurance oversight.



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PERIPrem Cymru



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PERIPrem – July 2026

July 2026

6 Infants

- 2 x 28 - 29+6
- 1x 30 – 31+6
- 3x 32 – 33+6

4 were EM LSCS

- 1 x 28/40 ex utero transfer from PCH, Gross fetal hydrops identified day of delivery (unable to optimise)
- 2 x (twins) background of PROM – Path CTG twin 1
- 1 x APH no optimisation, surviving twin, Congenital anomaly other twin (planned comfort care after birth)

2 were SVD

- 74% of infants received the whole PERIPrem bundle



How well have we optimised care this month in:

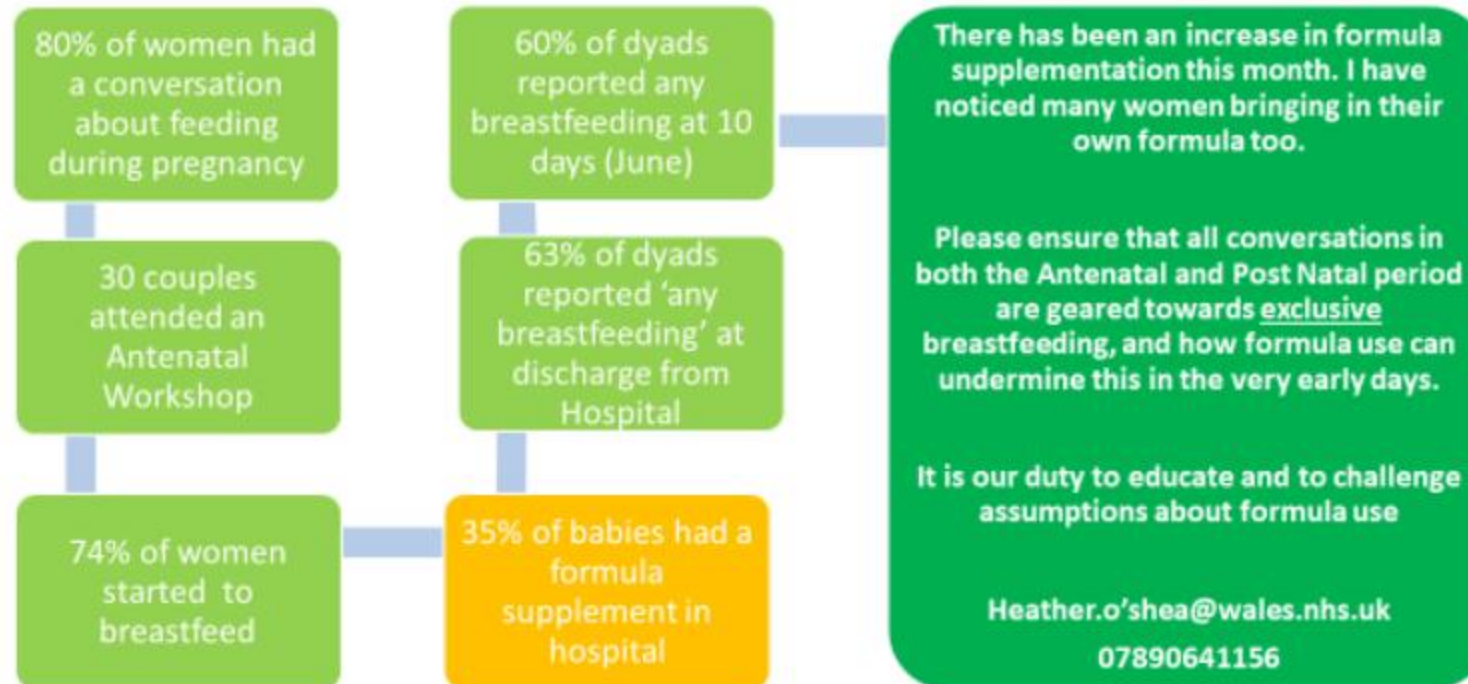
Singleton Hospital

Developed By:

	Month:	46204	Number of babies under 34 weeks gestation born at the unit this month		6	
	How many babies did we ensure were born in the right place? Target: 85%	100%	% antenatal interventions that <u>could</u> be optimally timed ↓	% antenatal interventions that <u>were</u> optimally timed ↓	 For babies that required ventilation, how many were ventilated using a VTV/VG mode? Target: 100%	100%
	How many babies mothers received antenatal steroids? Target: 85%	83%	20%	20%	 How many babies received caffeine within first 24 hour of life? Target 100%	100%
	How many babies mothers received antenatal Magnesium Sulphate? Target: 85%	100%	50%	50%	 How many babies received Early Maternal Breast Milk (EMBM) within 6 hours of birth? Target: 85%	67%
	How many babies mothers receive intrapartum antibiotics? Target: 95%	50%	100%	100%	 How many babies received a multi strain probiotic within first 24 hours of life? Target: 100%	67%
	How many babies benefited from Optimal Cord Management? Target: 85%	83%	Total % antenatal interventions that <u>could</u> be optimally timed →	38%	PERIPrem Bundle: Optimisation Score for the unit this month [Total number of interventions given/Total number of optimal interventions] 74%	
	How many babies had a normothermic temperature (36.5-37.5C) measured within one hour of birth? Target: 90%	83%	Total % antenatal interventions that <u>were</u> optimally timed →	38%	PERIPrem Bundle Optimisation: How many mothers and babies received ALL the interventions for which they were eligible this month? 0%	

Maternity Infant Feeding - Snapshot

July 2026 Infant Feeding Snapshot





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Risk register



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Risk Register – Monthly updates

ALERT

A number of high-scoring strategic risks remain dependent on organisational, regional or national solutions and therefore continue to present material residual risk.

ADVISE

Active mitigation plans, escalation processes and routine governance review are in place to reduce risk exposure and support informed decision-making.

ASSURE

The service demonstrates robust risk management arrangements, with clear oversight, early identification of emerging risks and appropriate escalation of strategic issues.

Perinatal Risk Register as at 03.08.2026

ID	Risk (in brief)	Rating (current)
340	Delayed ambulance transfers from NPTBC or home birth	15
342	Lack of permanent 24 hour Neonatal Transport Service	16
1462	Infant abduction by family member or stranger	5
2595	IOL - delay in induction of labour or augmentation of labour	16
2697	Split site working Obs Unit isolated from Critical Care & other surgical specialties	12
2706	Split site working – Obs Unit isolated from Childrens Unit	12
2788	Staffing levels - Midwifery	15
2886	Nurse staffing levels in Neonatal Services	9
3099	Lack of resources to sustain upkeep of parent accommodation	9
3135	Neonatal Medical Workforce	12
3363	Lack of soundproofing in bereavement suite for intrapartum care	15
3366	Lifts in Maternity Service Block	12
3427	Incubators more than 10 years old need replacing	6



Perinatal Risk Register ctd

ID	Risk (in brief)	Rating (current)
3429	Lack of weight management service provision in maternity	16
3622	Central Stations – replacement of vital equipment	12
3852	Neonatal Incubators 10+ years old (x2)	12
3853	Neonatal Incubators 7+ years old (x3)	9
4224	Increased rate of Caesarean Section	9
4407	Back-up Obstetric Theatre Size	12
4453	Lack of Full-Time Paediatric Radiologist Support for Neonatal Services	20
4472	Implementation of MoNET training as ‘business as usual’ for 2026 onwards	20
4533	Neonatal medical rota non-compliance resulting in patient safety, workforce, and financial risks	12
4573	New Risk 24.07.2026 Review of Serial Growth Scan Surveillance Pathway	12



Perinatal Risk Register – High level risks (scored 16-25)

Risk	Mitigating Actions/Additional Comments	Current Risk Score
ID 4453 – Lack of Full-Time Paediatric Radiologist Support for Neonatal Services	Escalated to Senior Leadership Team	20
ID 4472 - Implementation of MoNET training as 'business as usual' for 2026 onwards	New risk – added to Risk Register on 20.04.2026 – to be highlighted to Senior Leadership Group	20
ID 2595 - Delay in induction of labour or augmentation of labour	Plan to commence new induction of labour process in May 2026	16
ID 342 – Lack of Permanent 24 hour Neonatal Transport Service	Capital Funding is required	16
ID 3429 - Lack of weight management service	To be included as part of the Antenatal Improvement workplan – email to Public Health Lead Midwife for mitigating factors now in place to be able to reduce score.	16
ID 4533 – Neonatal Medical Rota non-compliance resulting in patient safety, workforce and financial risks	New risk added 16.06.2026 - New rota developed for resident doctors starting in September 2026 which is now compliant but has resulted in reducing workforce to 2 medics at night – mitigation a twilight shift ending at 00:00hrs to support night team.	16



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Patient Experience



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Feedback – Monthly updates

ALERT

Patient feedback continues to identify themes relating to access, waiting times, communication and postnatal experience, some of which reflect wider workforce and service pressures.

ADVISE

Feedback is actively reviewed, escalated and incorporated into improvement programmes, engagement activities and quality improvement workstreams.

ASSURE

Overall patient experience remains positive, with strong evidence of compassionate care, staff professionalism and meaningful family engagement.

Patient Feedback – 1st to 31st July 2026

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	86.3%	11.6%	95	57	25	2	2	9	0
Antenatal Clinic - Neath Port Talbot	96.0%	4.0%	25	21	3	0	0	1	0
Antenatal Clinic - Singleton	70.0%	20.0%	10	4	3	1	1	1	0
Birth Centre	87.5%	12.5%	8	7	0	0	0	1	0
Community Midwives	50.0%	33.3%	6	0	3	1	0	2	0
Labour Ward - CDS	85.7%	14.3%	7	6	0	0	0	1	0
Neonatal Intensive Care Unit	66.7%	33.3%	3	1	1	0	0	1	0
Transitional Care Unit	100.0%	0.0%	1	0	1	0	0	0	0
Ward 19 (Antenatal)	89.3%	10.7%	28	13	12	0	1	2	0
Ward 20 (Postnatal)	100.0%	0.0%	7	5	2	0	0	0	0

All negative feedback alerts with 'Very poor/poor' is sent automatically to Maternity management and PALS team who review the feedback and where possible contact (if contact details have been left) the patients and discuss their concern.

Friends and Family

For July 2026, the overall satisfaction score was 86.3%, based on feedback collected from friends and partners of the mums via QR codes and online links.

Poor/Very Poor Feedback

- I didn't like how inducing me felt forced. I wanted low intervention and this was pushed on me. Thankfully my partner advocated for me and asked if we could go for a walk before the decision was made. The walk brought me into active labour.
- Many parts to the appointment which involved long waits in between. One point one wait 1 hour 10 minutes for the next part of the appointment. In total it was 3 hours which was completely unnecessary. There is no system in place for waiting for blood tests after your scan so is a nightmare to get seen. Absolutely hated the whole experience and was treated like an animal more than a pregnant woman.
- The care Post natal was non existent
- I waited 3hrs at the hospital for my 12 week antenatal ultrasound appointment. I was told to arrive with a full bladder and then waited 30 minutes to be seen by the sonographer despite being the first appointment after lunch at 1.30pm. I then waited over an hour for a blood
- Partner unable to stay the night on postnatal ward. After having c section that morning, and looking after a newborn, having a partner there would be very beneficial. Physically and mentally!



Positive Themes from Friends and Family Feedback

This time around, much better experience.

Amazing staff on antenatal and labour wards!

Lovely staff!! Great service and care, thank you!

When being induced on ward 19 in singleton hospital on May 28th I had the same midwife for three consecutive nights, the care, compassion and empathy this midwife gave me was second to none and I will never forget how kind this midwife was to me. I would also like to mention that all students and other midwives I came in contact with on ward 19 during this time were all so helpful and kind. After a failed and traumatic induction I had an unplanned c section on Monday the 1st of June. I had a midwife who was incredible from start to finish, and I don't think my experience would have been as good as it was if it was not for this midwife! I am so grateful for her and would like to pass on my thanks to her! This midwife also had a student with her who was amazing, they were both so calm and knowledgeable which made me feel so much better about the everything. Also a huge mention and thanks to all the doctors/nurses who carried out my c section they were incredibly kind to me as I was extremely anxious and thanks to them my beautiful boy was safely delivered.

The NICU and ships experience and help was fantastic with great help for both parents. The labour ward was not the same. There are no male toilets no support or facilities for the fathers. No fridges or microwave to even make or keep food. Although being there 12 hours a day.

Ward 19 staff were wonderful. Can't fault them at all - the delays led to 12 days in hospital though which was awful. It was the labour ward where things turned pretty awful. There was also confusing and conflicting information around induction methods.

All the staff are always helpful and friendly. We are here twice weekly for the last 8 weeks, doctors, midwives and sonographers are great.



NHS Core Pilot Questionnaire – July 2026

Maternity Phase 1: Antenatal Clinic – NPTH & SING

No Data Available

Maternity Phase 2: Singleton Community Midwives

Results by Ward/Clinic

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	0.0%	50.0%	2	0	0	1	0	1	0
Community Midwives	0.0%	50.0%	2	0	0	1	0	1	0

Themes – Not enough data for themes



NHS Core Pilot Questionnaire – July 2026

Maternity Phase 3: Bay Birth Unit, Birth Centre & Labour Ward – CDS

Results by Ward/Clinic

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	66.7%	33.3%	3	2	0	0	0	1	0
Birth Centre	66.7%	33.3%	3	2	0	0	0	1	0

Not enough data received for themes.

Maternity Phase 4: Neath Port Talbot Community Midwives

Results by Ward/Clinic

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	75.0%	25.0%	4	0	3	0	0	1	0
Community Midwives	75.0%	25.0%	4	0	3	0	0	1	0

Not enough data received for themes.



NHS Core Pilot Questionnaire – July 2026

Maternity Phase 5: Neonatal Care Unit and Ward 5 (Special Baby Care Unit)

Results by Ward/Clinic

Ward/Clinic	% Good	% Poor	Total Responses	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know
Total	66.7%	33.3%	3	1	1	0	0	1	0
Neonatal Intensive Care Unit	66.7%	33.3%	3	1	1	0	0	1	0

Not enough data received for themes

Neonatal Outreach

No Data Available



Family Experience Story- A Premature Birth Journey

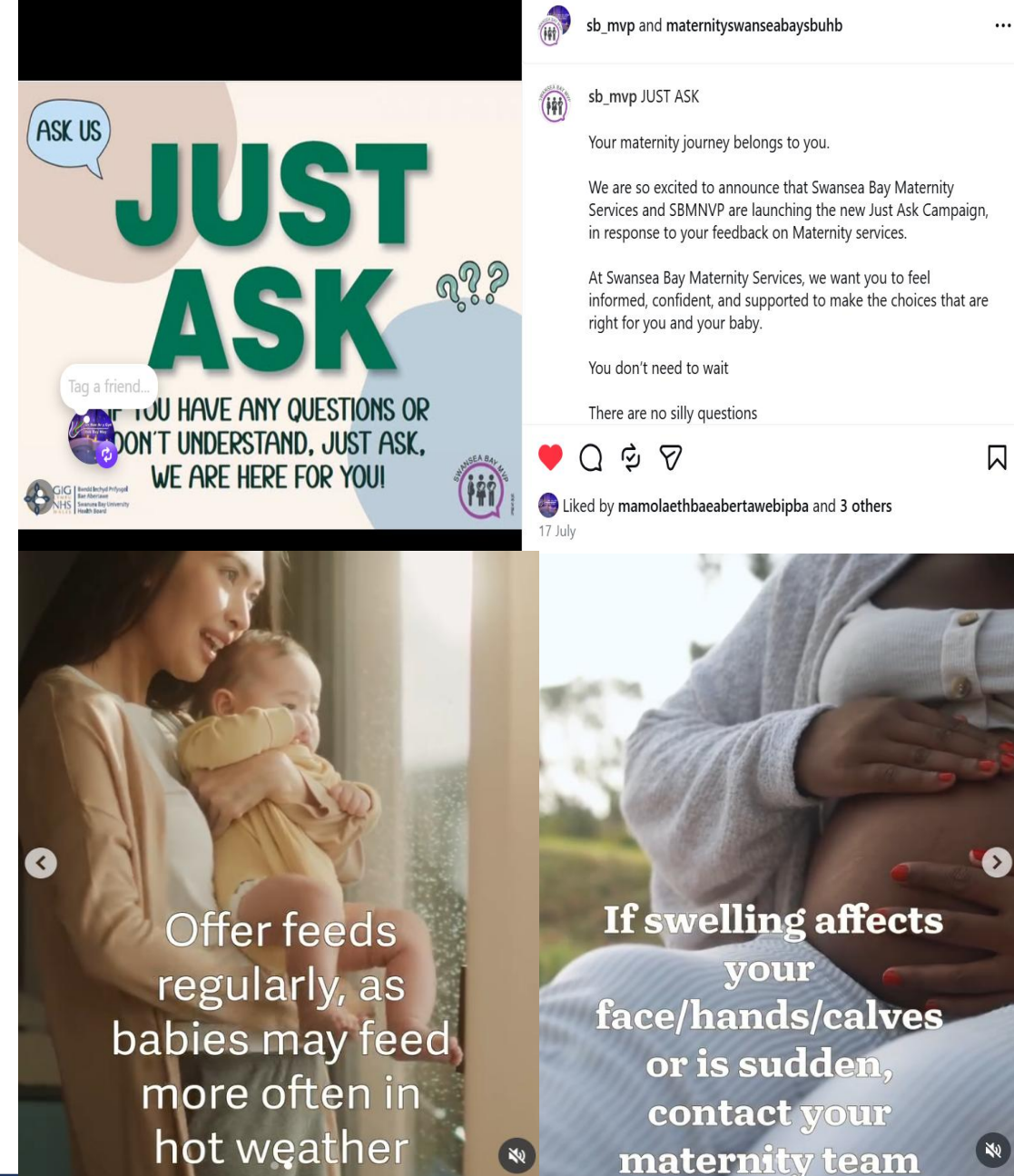


July 2026 Social Media Updates

- Birth Location imagery and proposed Maternity Statistics content were discussed at Intrapartum Forum: Following feedback it was agreed that the theatre section of the Labour Ward Tour Video would be updated to include staff. This aims to make the theatre environment appear less stark while giving families a more realistic representation of the number of staff they may expect to be present should they require Theatre care.
- Updated theatre photographs were taken by the Intrapartum Lead and shared with Communications team, who have now incorporated these into the video. The updated birth Location Tour is ready for release in August.
- Photo carousels for each birth location were approved. However, further photographs of Neath Port Talbot Birth Centre are required to better represent the wider environment and facilities available. These will be taken by the Family Experience Midwife.
- Further discussion took place regarding the design and presentation of Birth Statistics content. The Family Experience Midwife will develop additional design options to bring to the next Intrapartum Forum for review and note.
- Restrictions on social media posting were in place for much of July, reducing posting frequency and impacting continuity and engagement. The aim for August is to rebuild posting consistency and engagement following these restrictions.
- Currently content created by the Family Experience Midwife is approved by the Directorate and Head of Midwifery with relevant clinical oversight sought for content where required.
- The Just Ask Campaign was officially launched by the MNVP in July, with a collaborative post shared alongside SBUHB Maternity Services to help raise awareness of the campaign and its key messages.

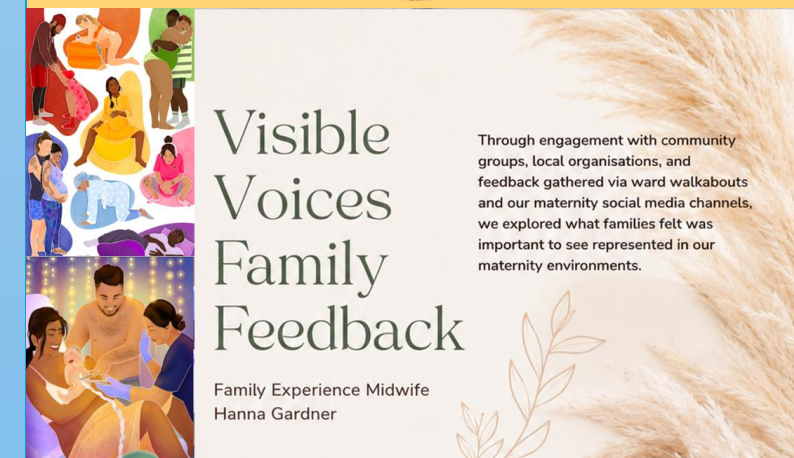


Maternity Social Media



Visible Voices Project Update

- Engagement has been completed with 8 community groups, with 49 survey responses received.
- Key themes identified through both family and staff feedback have been collated and shared with the artist Lauren Rebbeck to inform development of the artwork.
- The artist has also been provided with photographs of maternity environments, the Swansea area and staff uniforms to support accurate and locally representative illustrations.
- Discussions have taken place regarding potential artwork locations and formats, considering how individual pieces could best reflect and complement the spaces in which they are displayed.
- Many options for artwork discussed based of family and staff feedback. One option discussed was a story-style montage representing and IVF journey, which could be displayed within the antenatal clinic.
- The artist has now received the full feedback and supporting information required to begin developing the artwork.
- Next Steps: Awaiting the artist's first draft illustrations for review and feedback.



Welsh Identity and Language

- Welsh language incorporated into artwork.
- Welsh affirmations in birthing spaces.
- Welsh words such as "Cariad".
- Welsh flags, dragons and daffodils.
- Welsh speaker badges/pins represented.
- Strong sense of local Welsh identity

Maybe like Welsh pin on staff/midwife uniforms in the artwork to represent Wales, like the 'Welsh speaker' pins.

Welsh representations- as a Welsh
speaker I'd love
to see maybe Welsh affirmations written
on
the birthing room walls.

I'd really like to see Welsh representation. Like maybe a Welsh flag, daffodils, dragons. Maybe Welsh words in the art like "cariad".

Community Engagement Updates

- **Mums & Toddler Foundation:** Family Experience Midwife and Supervisor of Midwives attended a positive engagement session. A service-user story highlighting areas for improvement was shared and will be taken to Maternity Experience Forum, with potential to develop into a digital story for staff learning. Further collaboration discussed, including support for a planned fathers group and infant feeding support.
- **Sketty Mosque:** Family Experience Midwife attended alongside HIW to strengthen ongoing engagement. Invited to future events to build relationships and better understand families' experiences and needs when accessing maternity care.
- **National Autistic Society Swansea Branch:** Family Experience Midwife attended a local coffee morning, receiving positive feedback and suggestions to inform the Neurodivergent Maternity Passport and Visible Voices. Family Experience Midwife welcomed to future events.
- Continued focus on developing long-term community relationships and opportunities for families to directly influence maternity services.



maternityswanseabaysbuhb



maternityswanseabaysbuhb Working together to support women and families ❤️

It was a pleasure for members of our maternity team to spend time with the Mums and Toddlers Foundation last week. We're so grateful for the long-term relationship we've been able to build with this incredible Foundation, and for the opportunities to listen to and learn from their team and the families they support.

This latest visit gave us another opportunity to share ideas and explore how we can continue building on our work together. We're really excited about what's ahead and continuing to ensure the voices and experiences of local families help shape our

[View Insights](#)



Liked by [laurenrebbeck](#) and 11 others

1 day ago

Antenatal Assessment Unit Feedback

Caring, Professional and Reassuring Staff

The most consistent theme across all responses is the quality of staff interactions.

Women described staff as:

Kind, lovely, helpful, professional, fantastic, reassuring.

All respondents who commented on their interaction with midwives felt listened to and understood, contributing to positive experiences and confidence in the care provided.

High Satisfaction with Care

Most respondents reported being very satisfied with the advice received and the outcome of their contact with AAU.

Women felt:

Their concerns were taken seriously.

Appropriate reassurance was provided.

Decisions about assessment and care were clearly explained.

Supported throughout their pregnancy journey.

Several respondents stated they would not change anything about their experience.

Positive Telephone Contact

Most women found contacting AAU easy, particularly when using the direct telephone number. The direct line appears to be valued by those who have access to it.

Telephone Accessibility

One respondent reported significant difficulty reaching the service, describing repeated unanswered calls before eventually accessing support through another route.

Telephone Menu Navigation

One respondent felt the automated menu system was too long and could be frustrating, particularly in urgent situations or during labour.

Communication During Waiting Times

One respondent described waiting over an hour for assessment and felt there was limited communication regarding delays.

Patient Comfort While Waiting

One respondent reported being offered water which was not subsequently provided, suggesting an opportunity to strengthen attention to comfort measures for women waiting to be seen.





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Service Group Forums



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Forum – Chairs and Dates

Rhiannon Griffiths	Laura Rose	Melanie Llewelyn	Catherine Harris	Joanna Webb
Antenatal Forum	Intrapartum Forum	Postnatal Forum	Patient Experience	Neonatal CBM
21st January 2026	28th January 2026	9th January 2026	14th January 2026	First Thursday monthly
26th March 2026 29 April 2026	11th March 2026	20th February 2026	25th February 2026	
27th May 2026	22nd April 2026 20th May 2026	3rd April 2026	18th March 2026	
22 July 2026	3rd June 2026	15th May 2026	15th April 2026	
30th September 2026	15th July 2026	26th June 2026	20th May 2026	
26th November 2026	19th August 2026	7th August 2026	24th June 2026	

Antenatal Forum

ALERT

ADVISE

ASSURE

Intrapartum forum

ALERT

- 1.) Increased ELCS demand
- 2.) Guidelines outstanding: Perineal trauma and repair, Declining blood products, Responsibilities of team on duty
- 3.) MEWS parameters being used to monitor women in midwifery led birth settings due to BadgerNet implementation.
- 4.) ELCS diary to be digitalised – Digital midwife off work. To be discussed at consultant meeting and user guides created
- 5.) Labour ward funded for one theatre team only. Unable to staff three emergency theatres simultaneously out of hours

ADVISE

- 1.) Weekly review of ELCS booked and escalated for additional lists 2 weeks in advance.
- 2.) Guidelines are allocated for completion.
- 3.) Plan to monitor transfer rate and review 4 weeks from implementation.
- 4.) Will be utilising the booking system within badgernet, however risk deemed too high to implemented on go live date. Plan to create user guides and clinical RAG rating for booking electives.
- 5.) Use of second theatre SOP amended as per HIW recommendation and added to risk register =12
- 6.) Women with GBS able to attend BBU for intrapartum care. SOP and flow chart to be approved at Q+S

ASSURE

IP&C inspection 86%
Second stage 30 minute fresh eyes review to start September for 2 month review period
Video and photos for social media post finalised and ready for sharing with communities

Perinatal Postnatal Forum

ALERT

August meeting rearranged for September due to availability

ADVISE

ASSURE

Regular postnatal meetings continue to take place every 1-2 weeks on a Tuesday as part of PN ward Improvement plan



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One Bay Way

Neonatal CBM

ALERT

- HEIW Feedback for Neonates –
- National Training Survey training on our unit has been marked as a poor outlier – This was expected as many of the teaching sessions had been replaced with Governance.
- Top heavy Junior nursing workforce making some shifts difficult to cover skill mix despite having adequate numbers – increasing short term sickness in senior staff - on going
- Tier 2 medical rota 1.4WTE short continues - some flexibility in existing rota but Locums continue.
- Resident doctor contract changes will impact rotas from September 2026 – rota redesigned. Risk assessment to be completed due to reduced cover overnight
- Awaiting executive sign off for breast feeding coordinator, high risk as current BF nurse is going on maternity in 2 weeks (unit will be left without support)
- ~~MoNET – Risk Assessment completed~~

ADVISE

- An Education working group has been established and will identify any specific areas for improvement – bleep free teaching, specific feedback outside of GMC as been sought locally from existing trainees.
- AHP SBAR complete – for discussion and escalation
- Band 6 Annexe 21 job interviews taking place on 19th August, 8.98 WTE
- Proposal submitted for Transport ODN, along with UHW – Meeting being held 15th June
- Recognition that parental feedback remains to produce low numbers , Matron to organise a team to look at improvements – timeline 2 weeks (to feedback progress in next PA)

ASSURE

- Radiology reporting through Everlight successful to date
- Central line safety work progressing – ready for recirculation and planned to go to Q&S in mid-June for ratification.
- Receptionist vacancies filled - (1 has been given a start date, other awaiting employment checks)
- Band 7 x 2 posts at 1.6 WTE vacancies filled.
- Neonatal SCF position filled and will start in September 2026



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Actions and updates following HIW inspections and other review



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Actions and updates following HIW inspections and other review

HIW Report 2025 Neath Port Talbot Birth Centre

Two actions outstanding

The Health board should consider improving the hospital signage to the Birth Centre to help direct women and their birthing partners to improve overall experience

- The Health Board will work with the MVP and consider compiling maps of maternity services locations across the Health Board, including Neath Port Talbot for women and families to be fully informed of our locations and how to find us.

The Health Board should continue to complete the necessary action to work towards achieving the Midwifery Unit Standards

- The Health Board attended a Workshop in March 2025 for the implementation of the MUSA Standards – the Health Board will be working through a community of practice along with all Health Boards in Wales to deliver the standards as stipulated by the Swansea Bay self-assessment action plan. The Maternity and Neonatal Network have designed 5 Safety Huddles across Wales, the last being in September 2025, in which each Health Board will attend to share learning and good practice and will monitor progress against the MUSA standards. The action plan will be monitored via the service Perinatal Assurance Group and the Perinatal Committee for onward reporting to the Health Board QSR and Board/.



Actions and updates following HIW inspections and other review

HIW Report 2026

One immediate action – Resuscitaire checks.

Actions

- Update the current Safety Briefing to include the daily reminder and observation check that all resuscitaire's have been completed
- Revise the daily safety huddle to include a daily checklist including compliance with safety checks
- Hold a Band 7 meeting to discuss the finding from the inspection.
- Include a spot check audit of compliance against standard within the current regular Matron's audits.
- The service to explore with digital colleagues the potential of the introduction of SIGNAL a flag for resuscitaire checks.
- Implementation of Badger Maternity EPR includes a mandated field for resuscitaire checks.

HIW published their final report publicly on 21 May 2026. As well as the immediate action detailed above, the following headlines were reported:

What HIW found was working well

- Predominantly positive feedback from women and families: dignity, respect, involvement in decision-making and compassionate care.
- One-to-one care during birth consistently provided; birth partners supported.
- Stronger senior oversight, clearer governance and improved medical handovers (including daily safety huddles).
- Infection prevention, medicines management and safeguarding arrangements were assessed as robust.
- Improved leadership stability and clearer accountability structures following perinatal service reconfiguration.

Key concerns / areas for improvement

- Postnatal ward pressures: Timeliness of care affected by staffing and workload pressures; restricted visiting hours raised by some women.
- Workforce issues: Staff report feeling overworked, with concerns about staffing levels, training and professional development, particularly in postnatal and transitional care.
- Escalation and equipment: Need to strengthen escalation processes when timely senior clinical review is not available; inconsistent checks of neonatal resuscitation equipment identified (immediate assurance sought and provided).
- Welsh language Active Offer: Not consistently embedded, particularly among newer staff.

HIW has requested that we submit an update on progress by the 30 September 2026 - this is longer the usual 3 months, and follows HIW consideration of the targets in the improvement plan. Updates need to be provided to Risk & Assurance Team by 23 September to allow for internal signoff by CEO. The Risk & Assurance team will meet with colleagues to agree set-up in the AMAT system for update & monitoring, as the update to HIW will be pulled via the AMAT system.





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Actions and updates following External review recommendations and implementation



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Flash Report: Perinatal Improvement Plan, July 2026

Exec Lead:	Liz Rix, Executive Director of Corporate Nursing	Clinical & Operational Lead:	Kathy Greaves / Sujoy Banerjee / Michelle Mason Gawne / Cath Harris
Programme Manager:	Ffion Green, Programme Lead	Date of previous & Next Programme Board Meeting:	13 July 2026 / 14 September 2026

Headlines					
Key Achievements in Previous Month: - Perinatal Improvement Plan approved by SBUHB Board and Oversight Panel - Visit from Oversight Panel to NPT, Morriston and Singleton Hospitals on 17 June / Learning event and workshop with Oversight Panel on 18 June – event attended by approx. 50 members of staff. - Constructive meeting with Liverpool Women’s Hospital on operational arrangements relating to two-site working; including reciprocal learning opportunities. - Digital guidelines tracker is being refined following testing phase to ensure maximum functionality. Manual monitoring in place as mitigation in the interim. - Staff Engagement, Wellbeing and Retention (SEWR) Plan launched.			Priority Actions for Next Month: - Executive review of high-level options appraisal for reconfiguration of Perinatal Services from Singleton to Morriston site. Paper to be presented to Board in September 2026. - Gap analysis of PIP against Ockenden and Amos reviews to ensure thematic learnings are captured. - Redevelopment of psychology service proposal to embed trauma-informed care into Perinatal Services.		
Programme Milestones		Due Date	Status (on track/off track/completed)	Mitigating Actions	Owner
Single point of access maternity triage service		March 2026	Completed	Single access telephone live 2 March 26, communications shared with patients, staff, switchboard and on social media channels.	Interim Exec Med Dir /Head of Midwifery
Multidisciplinary Team Development Programme		April 2026	Completed	- Five of five sessions completed - Dynamic evaluation indicates positive feedback from attendees	EDoWorkforce &OD/ASGD CYP&W
Perinatal Engagement Framework first draft		April 2026	Completed	- Service has been undertaking targeted engagement via Family Experience Midwife. - Framework will enable evaluation review and reprioritisation of targeted engagement based on learning from stakeholder mapping exercise	DoICE/Head of Midwifery
Risk / Issue		Impact RAG	Owner	Mitigations	Date Added
Escalation of concerns for women attending non-maternity sites (formerly two-site working – long term solutions		Amber	Interim Exec Med Dir	- Options appraisal to be presented to Board in Sep 2026. - SOP and escalation framework for admission of pregnant women to ITU and non-maternity sites. - Integration into next Clinical Services Plan (CSP) - Escalation of risk from service risk log to HB Strategic Risk Log; raised risk with Welsh Gov.	Feb 2026
Fragility of long-term paediatric radiology service, including neonatal radiology		Amber	Interim Exec Med Dir	- Interim outsourcing arrangement agreed Jan 2026. - Collaborative regional solution to be investigated – following discussions with C&VUHB in May 2026, further discovery discussion with University Hospitals Bristol and Weston NHS Foundation Trust on regional operations.	March 2026
Decision required by Executive Board today					
None					

Key Risks and Pressures

The service continues to operate safely but within a context of workforce fragility, operational pressures and several strategic risks that require ongoing organisational and system-level support. Key challenges remain around workforce sustainability, specialist service dependencies, digital stabilisation following BadgerNet implementation, review timeliness for complex governance processes, and delivery of specific specialist training programmes. Whilst controls remain effective, a number of risks continue to rely on actions beyond the direct control of Perinatal Services, including radiology provision, neonatal transport, workforce supply and national programme delivery.



- Risk Assessment Completed – 4 Weekly Scanning
- Perinatal Vacancies (as at 18th of August – as on TRAC)
- Clinical Lead Neonates – Executive Panel
- SCF Neonates – Executive Panel
- SCF Obs & Gynae – Executive Panel
- HCSW Maternity – Executive Panel
- Neonatal Staff Nurse – Executive Panel
- Infant Feeding Lead Neonates – Executive Panel
- Professional Development Lead – Service Group Panel
- Quality Improvement Performance Lead – Service Group
- Digital Informatics Lead Midwife – Back in DRAFT (AM to sort)
- Family Experience and Engagement Midwife – Service Group Panel
- Lead Sonographer – Service Group Panel

Mitigations

- Agreement for External Bank for Sonographer to work
- External Bank for Nursery Nurse

Mitigations, Decisions Required and Next Steps

The Committee is asked to note the significant programme of improvement and mitigation activity underway across quality, safety, workforce, digital transformation and governance. Recruitment activity continues across maternity and neonatal services, recovery plans are in place for training, incident review processes continue to mature, digital optimisation work remains active following BadgerNet implementation, and improvement programmes are progressing through the Perinatal Improvement Plan, QMS prototype work and service-specific quality initiatives. Ongoing executive oversight and support remain important to sustain progress and reduce residual risk exposure.

Committee consideration: Oversight of strategic risks and workforce sustainability. Continued support for system-level escalation where required. Assurance that learning, improvement and mitigation actions are translating into measurable benefits for women, babies, families and staff.



Reporting for Perinatal Committee

ASSURE

Areas of Strong Performance and Positive Assurance

The overall position remains one of improving quality, strong governance oversight and sustained commitment to continuous improvement.

Evidence within the report demonstrates positive patient outcomes, strong compliance with statutory training requirements, effective infection prevention arrangements, sustained reduction in HIE rates, robust mortality and incident review structures, improving patient engagement mechanisms and active risk management processes. Despite ongoing pressures, the service continues to demonstrate organisational learning, compassionate care and a proactive approach to quality improvement.

Alert, Advise, Assure Summary

Overall Assurance Opinion: Moderate to High Assurance.

The Committee can be assured that appropriate controls, governance arrangements and improvement programmes are in place and operating effectively.

Residual risk remains principally related to workforce sustainability, specialist service provision and wider system dependencies, which continue to require organisational and regional support.

