

Swansea Bay University Hospital Maternity Services Quarterly Assurance Report for the Cabinet Secretary for Health and Care

Swansea Bay maternity and neonatal intervention, Independent Observer

Date: 11 March 2026

To Note in this Quarter

- SBUHB improvement plan has been finalised Board signed off in principle at meeting 29 January for scrutiny by the oversight board on 23 February 2026.
- Ownership of elements of the plan has been spread across the executive team. ensuring a sustainable approach to improvement.
- Implementation of Standard Operation Procedures to support safer two site working.
- Publication of all Wales maternity assessment on 25 February which reflects similarities across Wales in some of the areas for improvement and proposes all Wales improvement opportunities for example for triage. SBUHB triage model implementation will now be part of the all Wales approach. A single unified SBUHB triage telephone line has been put in place to mitigate risks while the all Wales triage is established.
- Health Inspectorate Wales have inspected the unit and a report will be published in the near future.

In summary progress has been made in establishing and implementing governance arrangements, stabilising the midwifery and neonatal nursing workforce and in mitigating some of the immediate safety risks. Further work is needed however to ensure continuous Improvement in quality and safety is demonstrated as governance and operational structures mature.

1. Situation

1.1 This is the second quarterly report from the independent panel member appointed by the Welsh Government (WG) to the Swansea Bay University Health Board (SBUHB) maternity services oversight panel. The report will provide assurance of progress to date by SBUHB in implementing the recommendations of the independent maternity review and in meeting conditions set by WG to support de-escalation from level four of the WG escalation framework.

2. Background

2.1 An independent review of maternity and neonatal service was commissioned by Swansea Bay University Health Board in December 2023 to provide assurance about the services delivered and to identify opportunities for service improvement. The review was overseen by an independent panel which has played a key role in providing assurance about all aspects of the review and ensuring the review was delivered in line with the terms of reference. This review was published on 15 July 2025 and made ten priority recommendations, which are supported by more detailed service-specific recommendations for the health board.

2.2 On 13 May 2025, Llais published their Swansea Bay University Health Board Maternity Services Insights Report. It sets out the experiences from 512 people about their journey through pregnancy, birth, and postnatal care who have used maternity services within the last few years. On 14 July 2025, the Swansea Bay maternity support group published its family led review into Swansea Bay maternity services with over fifty families contributing to the report.

2.3 There were common themes running throughout all reports related to poor communication and advice; trauma and fear; women and families feeling ignored; about a lack of compassion and care; informed decision making; access to care; and birth partner separation. They highlight unacceptable patient and family experiences, cultural issues, staffing, training and resource issues, environmental and safety concerns.

2.4 As a result maternity and neonatal services at Swansea Bay University Health Board were escalated to level 4 - Targeted Intervention - of the Welsh Government escalation framework in July 2025. Welsh Ministers have agreed that the intervention would be focused upon the appointment of an independent member to sit on the oversight panel who will provide assurance to the Welsh Government and liaise with families on progress in implementation of all health board recommendations. Ann Gow the Independent member of the panel was appointed on 4 September 2025 to act as independent observer and critical friend on the oversight panel on behalf of the Welsh Government. This report is the second quarterly assurance report.

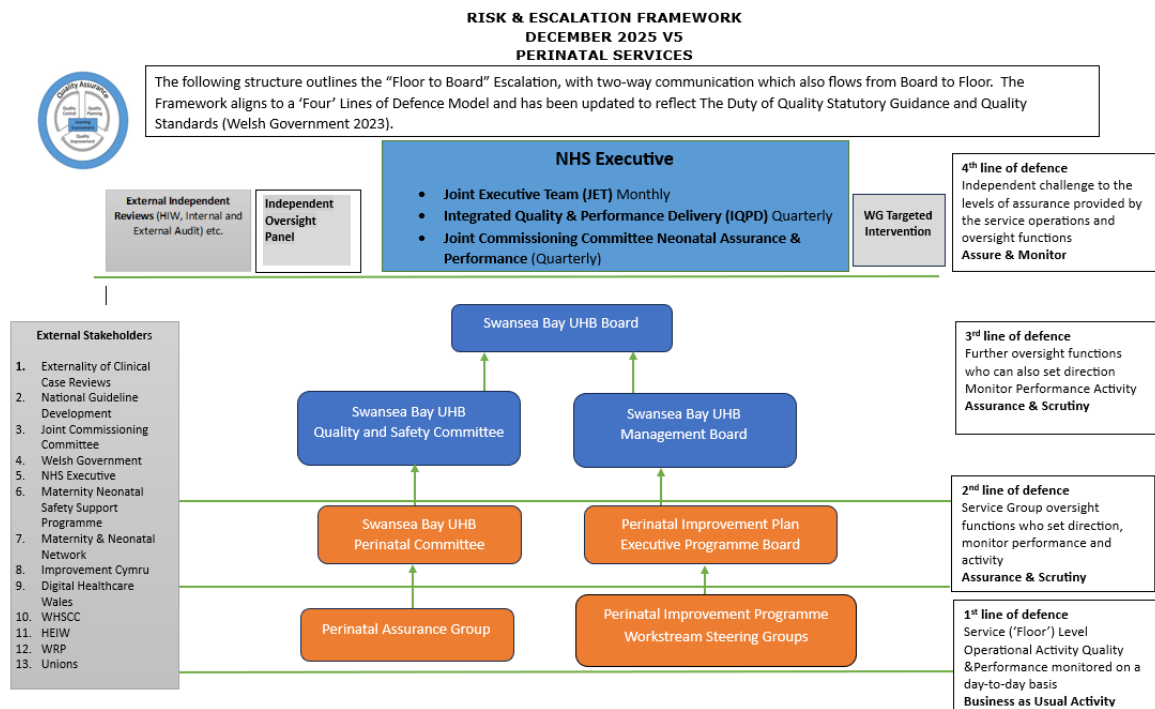
3. Assessment

Progress has been assessed against areas in the escalation framework as follows.

3.1 Governance and leadership

3.11 A clear governance structure is now in place which includes the provision of assurance to a perinatal committee. A non-executive lead for perinatal services has been identified. The perinatal committee meets monthly and reports to the Quality and Safety committee and from there to the SBUHB (figure1). There are parallel structures in place for reporting Business as Usual (BAU) assurance activities and Perinatal improvement plan activities to ensure focus on improvement continues.

Figure 1



3.12 The Executive Director of Nursing is the senior responsible officer for improvement of the service. The ten thematic recommendations from the Independent Review of Maternity and Neonatal Services, Family Led Review of Maternity Services have been grouped into four priority actions each led by a member of the executive team as follows-

- **Theme 1: Clinical Critical Safety Actions**, Executive Medical Director
- **Theme 2: Family Engagement**, Director of Insight, Communications and Engagement
- **Theme 3: Workforce / leadership / education and training**, Executive Director of Workforce & OD
- **Theme 4: Governance**, Director of Corporate Governance

3.13 A report on progress to date including the improvement plan and immediate mitigations was presented for assurance to SBUHB on 29 January. The report contained an overview of progress across all areas of the improvement plan and some benchmarking of data where available. The report highlighted no areas that would flag as a negative outlier for this quarter. A recording of the meeting and discussion is on SBUHB website.

3.2 Workforce

3.21 The perinatal committee provides oversight of staffing, staff learning and development compliance and staff wellbeing and support. The report highlights band six vacancies in midwifery and neonates with an over-establishment of band five and a plan to develop the band five cohort at pace to fill band six vacancies. Gaps are noted in obstetric and neonatal medical workforce with active recruitment and management underway.

3.22 There is a multi-disciplinary leadership development plan in place with actions commencing in January 2026. The senior leadership team are involved in piloting a programme led by Professor Michael West focusing on compassionate leadership. If successful, this will be rolled out across Wales.

3.23 A learning and development plan is in place for pre-natal services with compliance monitored at the perinatal committee. In January training on Maternity Early Warning Systems (MEWS) spread to Emergency Department staff and staff in Gynaecology.

3.3 Quality improvement

3.31 An improvement plan has been agreed by the board and the oversight panel as detailed above. This has been described as a “working document” and will be subject to change with agreement of the oversight panel as the plan progresses and opportunities, risks and issues emerge. Implementation of the plan will be monitored via the established governance structures internally with the oversight panel continuing to provide external critical friend support. It is anticipated that the oversight panel will step down in Autumn 2026 which will be a critical point in ensuring that SBUHB have a sustainable approach to the assurance and improvement of the maternity and neonatal service.

3.32 The perinatal service report highlights the use of a structured Quality Improvement Approach to improvement highlighting examples of improvement programmes undertaken. In December 2025 the perinatal service was included in a test of the Welsh Quality Management System approach with an aim of strengthening improvement and assurance of the perinatal service. There are opportunities to build on current utilisation of improvement methodology to build a more systematic approach to continuous management of quality across the service.

3.4 Quality and safety

3.41 Quality and Safety metrics are presented to the peri-natal committee for oversight and assurance. The report provides an overview of the data with improvement actions where necessary. The oversight board have reviewed that report and are in discussion with the team around some areas which could be further improved and where deeper understanding of the data is necessary to support the committee and board in understanding the data and ensure targeted improvement actions.

3.42 Dashboards to aid assurance and oversight of the service are in place. Complaints, concerns and incidents are reported to the perinatal committee. Immediate oversight of incidents and risk reduction takes place via case strategy meetings. Staff involved in reviews have received training and use a standardised systematic approach. The number of investigations delayed in completion has reduced. In particular further work is underway in engaging families in the review process and ensuring timeliness of responses to incidents and concerns. A plan is in place for improvement in quality of incident review.

3.43 There has been some progress in mitigating specific immediate safety risks identified in the review. A single telephone triage line has been implemented in February 2026. Further improvement in triage safety will be part of the all Wales triage approach recommended in the All Wales Assessment of maternity and neonatal services. Delays in induction of labour are now monitored and triangulated with any harms. A process to improve risk-based

assessment for induction is underway. Standard operating procedures are in development to support care of pregnant women in non-maternity services – a particular risk associated with the distance between the Singleton and Morriston sites. Neonatologists are interpreting radiological results (for example plain film) on site while a further solution to a shortage of paediatric radiologists is being sought at national level. National support will be needed for solutions to sustainable triage and paediatric radiology issues on an all Wales or regional basis.

3.5 Women and family engagement

3.51 Engagement of women and families forms a key part of the improvement plan. Work has commenced on developing patient engagement, Sources of feedback have been mapped and reported at perinatal committee. A women's experience specialist midwife is in post. Patient feedback is being collected as part of a pilot of a core patient feedback questionnaire. Issues are responded to in real time, if possible, by the midwifery team. Feedback from women using the triage service is being gathered. A Black and Minority Ethnic advisory committee is being established, and staff are training in equality, diversity and inclusion.

3.52 There are some working examples of family co-design including an Induction of Labour Leaflet, change to visiting times on back of family feedback, and the introduction of Infant Feeding Advisors who continue to have a significant impact on the PN Ward. Satisfaction rates with feeding support are excellent and the breastfeeding at discharge rate has risen since their recruitment.

3.53 Development of a perinatal engagement strategy is contained in the improvement plan with a deadline of June 2026. This will be key to the sustainable meaningful involvement of families in the design, delivery and improvement of services. The oversight panel are continuing to support the executive team to further develop engagement to strengthen the boards approach in this area.

4. Next steps

4.1 The oversight panel and independent reviewer will continue to act as critical friends to the board and executive. This will support the board in maturing the plan, strengthening governance, use of data and family engagement. A further in person event and walk round of the service is planned for June 2026.

5. Recommendation

It is recommended that the Cabinet Secretary accepts assurance that there is progress since the previous quarter. An improvement plan has now been completed and will be finalised subject to the advice of the oversight board. Governance structures have been established for both business as usual oversight and for the improvement of services. Mitigations are in place or in development for the critical safety issues identified by the oversight panel in the review. Further work is needed to implement the plan, respond to any recommendations from the all Wales assessment, continue to fully develop family engagement and ensure a sustainable approach to managing safety and quality of the perinatal services within SBUHB. It is recommended that oversight continues to support SBUHB in implementation and provide assurance that improvements are delivered. A key review point will be in Autumn 2026 when the oversight board have planned to step down.