Appendices

Appendix contents

This appendix pack should only be used in conjunction with **The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board (2025).** This pack provides information and data relating only to that review and is not meant for any other purpose.

Appendix 1 – Terms of Reference

1. Introduction

This document sets out the scope and Terms of Reference for an independent review into the Maternity and Neonatal Services of the Health Board (the Review). The Review has been commissioned by the Health Board to enable it to receive a broad range of independent expert analysis of its services and valuable input from families and staff. By means of this Review, it is seeking to ensure that all identified safety actions are fully implemented and monitored to ensure that any improvements in the services can be sustained.

2. Background

The Health Board's Maternity and Neonatal services have been the subject of scrutiny since at least 2019 and in the last five years there have been a number of internal and external reviews, and these are summarised in the Appendix [below].

The findings of those reviews included common themes around patient experience, governance, departmental culture and clinical care. The Health Board has previously accepted the findings of these reviews and developed resultant improvement plans to support services to learn and improve outcomes for women, babies, and their families. However, the Health Board is very much aware of ongoing concerns within the local population which it serves and, in light of the MBRRACE-UK data, the current Review has been commissioned to determine whether recommendations arising from previous reviews identified all learning and resulted in appropriate improvements in the service and, importantly, whether, and if so what, problems persist or have arisen since those reviews that need resolution to ensure the safety and effectiveness of the current services and to rebuild trust and confidence in them.

3. The aims of the Review are to:

a. Ensure that family and staff experience of the Maternity and Neonatal Services is central to this Review, its findings and impact so that learning from experience can be identified.

b. Ensure that any harm identified in individual cases is communicated to service users in line with the Health Boards obligations under the Duty of Candour.

c. Undertake a rapid review of departmental risk to establish if there are any significant unaccounted risks within the current service. This will inform the need for any safety actions required at an early stage whilst the broader review is ongoing.

d. Consider the clinical care within the scope of these Terms of Reference to determine its role in outcomes for mothers, babies and families.

e. Understand key contextual data such as demographics; population health, and, for example, inequality data; and departmental activity to identify contributory issues.

f. Consider the wider impact of the pandemic on activity and governance.

g. Consider, on a ward to board basis, the current leadership, quality, culture and governance arrangements within and (relationships) between services and understand why previous reviews may not have led to sustained improvements.

h. Consider themes across all review strands and provide overarching analysis and reporting of both historical (from 2019 when the external reviews began to highlight serious concerns) and contemporaneous issues within maternity and neonatal services.

i. Provide recommendations to improve the Health Board's Maternity and Neonatal Services and outcomes for babies and their families.

j. Identify actions the Health Board needs to take to establish effective engagement arrangements which actively involve patients, families and staff in the improvement of Maternity and Neonatal services and to rebuild wider public trust.

k. The Oversight Panel will seek evidence and assurance from the Health Board that high priority actions have been implemented on an urgent basis and that all other recommendations arising from this Review have also been implemented and embedded within a reasonable timeframe.

4. Terms of Reference

The Review, as above, will comprise of 7 strands and final review output coordination:

- A review of any current departmental risks;
- Clinical care provided (the Clinical Review);
- Family and staff experience (the Engagement Review);
- Data and contextual analysis;
- Pandemic impacts;
- Leadership; quality; culture, learning, and governance (the Governance Review); and
- Output coordination.

This will be a coordinated review comprised of independent expert reviewers who will undertake the Review. Teams will work collaboratively with one consultancy team pulling together an overarching final report with recommendations.

5. The Role of the Oversight Panel

- Review progress of the Review as well as escalate any project risks and relevant matters arising directly to the Health Board's Board.
- Any immediate risks to patient safety (not identified in the current controls report) will be escalated immediately to the relevant clinical team and notified to the Oversight Panel for onward transmission to the Health Board's Board and to any other relevant body as necessary.
- Undertake an ongoing assurance process in respect of the scope of the Terms of Reference with a view to considering any feedback from the Review teams regarding any need to expand the scope of cases being considered and expand the same as necessary.
- Provide independent scrutiny to ensure the Review is completed in line with the Terms of Reference. However, the Oversight Panel is aware that it does not have the right to amend, alter or influence the primary findings of the independent review.
- Following completion of the Review, it will continue to oversee the implementation by the Health Board of any recommendations made against agreed milestones.
- As this is a report in the public interest, the Oversight Panel will be responsible for arranging any legal review prior to publication of the final report. The legal review will predominantly confirm whether the final report has met the Terms of Reference and whether the report is suitable for publication. The legal review will not have the power to override any of the independent findings.
- The Health Board will have no role in the carrying out of the Review or in the preparation of the final report and its contents will be entirely the responsibility of the independent reviewers.

6. Scope and Methodology

6.1 Review of current departmental risks

This is an important initial stage in a multi-factorial review process (which may take extended time to complete) and offers up-front assurances on current departmental safety as well as any urgent

remedial actions which are required (and may not already currently be being addressed). This will include an assessment of:

- current live operational and safety risks;
- any risks which have not yet been captured or scored appropriately;
- any risks which may be compounded (and therefore more urgent);
- the risk mitigation and decision making on the risk; and
- any urgent remedial actions required (if at all).

6.2 Clinical Review

To determine the safety of the current service, the Clinical Review will assess maternal and neonatal care provided in the calendar year 2022 using a standardised assessment tool as follows:

- All MBRRACE-UK reported stillbirths and neonatal deaths;
- All neonatal deaths <24 weeks gestation (not currently reported by MBRRACE-UK);
- All babies who died on the neonatal unit >28days;
- All babies who received therapeutic hypothermia for presumed hypoxic ischaemic encephalopathy;
- All babies transferred out for intensive or high dependency care;
- All term babies who received intensive care;
- To undertake a clinical review of the admissions of pregnant women (including <6 weeks post-natal period) to ITU during the review period 2020-2024, to identify any additional learning opportunities for the Health Board; and
- To seek assurance on the learning from maternal deaths as reported to the Health Board between the same time period.

These categories of cases encompass the outcomes that are known to provide the best information about the standard and quality of maternal and neonatal care delivered.

Secondly, all deaths reported by MBRRACE-UK for the calendar years 2020 and 2021 will be reviewed to specifically identify whether themes arising from clinical care contributed to the Health Board being flagged 'red'.

Thirdly, there will also be an opportunity for families to self-refer if they have had experiences of events that are not covered in the above list and would like these to be included in the External Independent Review.

The Clinical Review team will ensure full compliance with all of the Health Board's Information Governance protocols and the approach will consist of:

- engaging with the perinatal team prior to the Review commencing, to describe the Review. Meetings will also be held with the Executive Team and Service Group;
- review all health records in the groups described above, including clinical incident records and any investigation reports (including rapid reviews, full investigations, PMRT reports) covering the antenatal, intrapartum, postnatal care of the women and neonatal care;
- working with the governance and data review team to support the identification of trends and themes, producing relevant source materials (including data, graphs, trends, diagrams) which can be transferred into the overarching report;
- highlight any case in which the Clinical Review team judge that any modifiable factors might have impacted the outcome of care for mother and/or baby;

- consider whether the national and local standards for reporting deaths were met;
- ensure that the experiences, views and questions of families are included in the review of their care;
- produce a document of key findings with recommendations to feed into the overarching report which help facilitate the Health Board in developing an action plan with the Oversight Panel;
- to provide detailed clinical information to the Health Board to support their onward communications with families under Duty of Candour; and
- to provide a feedback session to the clinical teams.

6.3 Engagement Review

Families' perspectives and recognition of the impact on families are key components of any perinatal service review, and their lived experiences are essential in identifying areas both for service improvement and where service delivery is exemplary. *"Parents, ..., are the only individuals who were present for the whole of the pregnancy and therefore have a unique perspective on everything that happened to them and their baby" (NPEU, Parent Engagement Materials)."*

Consequently, the independent external engagement lead will work closely with families, service users and others who have an interest in improving maternity and neonatal care to make sure that that their voices are heard throughout the engagement process and that methods used meet their needs.

The feedback from service users will be captured from January 2019 onwards in order to provide invaluable input into their lived experiences (although it is important to note that other cases will be considered for inclusion).

The core activities of the Engagement Review Team are:

- Establish an Engagement and Communication Group to ensure that all perspectives, especially those of families, are heard and shape the co-production of the engagement process, communication and information;
- Identifying families who wish to be involved in the Review (they may include existing complainants, families who have had positive experiences, families who have suffered previous loss and damage and anyone who has used maternity and neonatal care;
- Devise multi-platform communication approaches and provide information relating to the conduct and progress of the review and its independence, ensuring there are opportunities for families to shape how they might want to be involved and receive feedback on findings and the impact on change and improvement;
- Liaise with independent, community and third-sector organisations and groups, including the Maternity and Neonatal Voices Partnership (MNVP) and Llais for support in accessing different groups and communities to ensure that everyone impacted has the opportunity for their voice to be heard;
- Work with families to understand how they want to be supported to share their experience, especially in telling their stories in contributing to the clinical review process, and explore what further support mechanisms they may want to access;
- Undertake a mixture of interviews, focus groups, drop-in sessions, visits, surveys, listening exercises and other approaches suggested by families and service users to understand their views;
- Review experiential feedback from existing mechanisms such as Friends and Family questionnaires, surveys, complaints, concerns and other methods for gaining feedback on satisfaction with care; and

- Understanding the views of other stakeholders such as GPs, community groups, voluntary, self-help and support organisations with an interest in maternity and neonatal care.

Themes, findings and case-studies will be developed into a thematic document of key findings with recommendations to feed into the overarching report which identifies the messages, concerns and recommendations for improving care. This will be a key component of the overarching review report.

6.4 Staff Engagement

- Undertake an exercise with staff where engagement 'key lines of enquiry' can be developed to understand the experiences of staff at all levels and within all disciplines, working within these services since the start of 2021;
- Staff outside these timescales can also contact the Niche email link to contribute to this review;
- Working closely with the governance review team to adopt a staff survey which covers aspects of experience, governance and culture;
- Reviewing existing information on any issues with culture or staffing through 'speak-ups' existing staff surveys and any culture reviews previously undertaken; and
- To identify and approach staff who may have left the service.

6.5 Data and contextual analysis

Build a bank of contextual data in order to support and cross-reference with other findings to add a depth of understanding to the final report, including:

- Departmental capacity and patient flow (including outcomes such as ambulance diverts in the event if the unit is either closed or diverting some admissions to other units);
- Birth rates on a rolling month by month basis – comparable to yearly averages (over 3-5 years);
- Core demographic information (ethnicity, age, wealth indicators, health indicators, health inequalities);
- Epidemiological analysis (population risk factors, GP liaison, genetic risk factors)
- Staffing and safety (staffing levels (adjusted), staffing skill mix (inc. locum), shift fill rates, departmental activity by incident); and
- Reports from regulators, royal colleges, etc.

6.6 Pandemic impacts

Using both data and governance review information the Review will examine the main impacts of the pandemic, which impacts upon the timeline under review, this will include:

- changes to process and governance which may have impacted upon access to services / outcomes;
- epidemiological information (latest maternal/covid research);
- impacts upon incident rates;
- definitive before and after picture along a timeline, with contextual data; and
- links to demographic impact/maternal outcomes of COVID.

6.7 Governance Review

The governance review team will:

- review historical governance arrangements since the start of 2021 including changes to governance during the pandemic and the potential impact of this on outcomes;

- review current governance arrangements and identify whether residual gaps exist;
- understand whether actions arising from previous reviews have been delivered and are sustained;
- understand whether processes for risk management are sufficient to effectively mitigate risks to the quality of care;
- understand current culture, safety culture / system, culture changes and strategic plans to improve culture;
- review how practitioners' performance concerns are managed;
- understand the overall incident profile of the units since the start of 2021;
- understand the complaint and claims profile across the units across since the start of 2021;
- understand how intelligence is being routinely extracted to understand the quality of services;
- review meaningful learning and understand how it is shared and acted upon;
- review Board information, timeliness and understand the sufficiency to provide proper assurance on the quality of services and patient experience;
- review systems of control and establish if there is clear accountability around those systems. Are escalation routes robust and is action taken where issues are identified?
- understand inter-relationships between partners, service-users, regulators and staff;
- review processes for service changes and policy updates throughout maternity and neonatal services; and
- establish if roles are clearly defined and are structures designed to support collaborative working.

6.8 Output coordination.

Includes the governance review team undertaking a core secretariat role in pulling the review together into a singular report plus appendices. Ensuring responsibility for seeking assurance from both the clinical team and the engagement team on findings in order to ensure that findings are cross referenced and that there is a final, cohesive report, particularly to:

- Support the clinical review team and experience review team to optimise the scope to ensure that appropriate quantitative and qualitative data can be extracted to support 'the findings.' This will ensure that correct approaches are used from the outset;
- Coordinate regular check-ins so that emerging findings can be fed between each of the work streams. This is helpful to expand key lines of enquiry as they arise;
- To provide formal project updates to the Oversight Panel on a bi-weekly basis and to coordinate feedback to the standing Oversight Panel across all work streams;
- Ensure that duplication of effort is minimised between teams;
- To seek clarification on any information which is used to form the basis of 'the findings,' to request further information if necessary and to ensure information is provided in a reliable format;
- To produce a draft, evidence-based report and recommendations and to oversee all quality control and validation checks on the final report;
- To oversee the factual inaccuracy checking process and any right of to produce a final, validated report; and
- To produce an abridged learning bulletin for further distribution if required.

7. Required Output of the Review

The outcome of the Review will be a detailed 'overarching report' incorporating the findings from the seven core aspects of the Review (and any matters arising during the Review which are deemed significant within the context of the scope). The independent overarching report will make recommendations to the Health Board to take forward all learning. The Report will ensure all staff and service user data and audit information is anonymised [where needed].

The Oversight Panel will provide a monthly update on progress to the Health Board.

Regular updates will be published as the Review progresses.

8. Access to Documents

The Health Board will cooperate with the Review Teams to provide documentation / access to information / staff as required. The Health Board understands that any delays in the provision of staff or valid information for review may impact the timescales, reliability, and cost of the Review work streams. See resources.

9. Interrelation of family involvement with legal proceedings

Contributions from families within all aspects of the Review will not affect or impact upon any legal remedy which they may be pursuing or wish to pursue in the future. Further, as set out above, any contributions which form part of the final report will be fully anonymised before publication and their confidentiality ensured.

10. Timescale

The aim is for the Review to conclude within 12 months, once all of the baseline information for review has been received by the review teams. The Review timeframe could be extended depending on the level of self-referral cases to be considered. Any immediate departmental risks will be reviewed at the outset of the Review to provide assurance to Service Users.

11. Resources

Resources for the Review will be funded by the Health Board, noting that such resources will be, as far as possible, commissioned from an independent source. However, the Health Board recognises that there will be a significant resource requirement for internal teams in order to supply the information required to deliver a review of this nature. This must be assessed fully for the impacts on operational performance during the timescale of the review. The clinical review team particularly, will require care records and case associated documents in a format which is orderly and accessible.

APPENDIX

June 2019	Health Inspector Wales (HIW) Inspection: a. Labour Ward: b. Ward 18 & Ward 19 (including Antenatal Assessment Unit); and c. Midwifery-Led Unit, Singleton Hospital.
October 2019	HIW Inspection: Freestanding Neath Port Talbot Hospital Birth Centre.
May 2022	Maternity and Neonatal Network assurance framework incorporating the three key report recommendations from: a. Shrewsbury and Telford Hospital Trust; b. Cwm Taf University Health Board; and

	c. HIW (2020) National Review: Maternity Services
August 2022	Maternity & Neonatal Network: Maternity Services Governance Process Review.
January 2023	Welsh Government Maternity and Neonatal Improvement Programme site visit.
July 2023	Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru - Discovery Phase Report (July 2023).
September 2023	HIW Inspection: a. Maternity Unit, Singleton of Ward 20; b. Ward 19; c. Antenatal Assessment Unit (AAU); d. Labour ward (including bereavement room); e. Bay Birthing Unit; and f. Low Dependency Unit.

Appendix 2 – Glossary of key terms used

Term	Definition
ABUHB	Aneurin Bevan University Health Board.
AHP	Allied Health Professional. AHPs are a category of health care professional that provide a range of diagnostic, preventive, therapeutic, and rehabilitative services to patients; examples include radiographers, physiotherapists, dieticians.
Alongside midwifery unit (AMU)	A midwifery led maternity unit which is located in the same hospital as an obstetric unit, so has access to obstetric, neonatal and anaesthetic care on site.
AMaT	Audit management and tracking software which captures and monitors clinical audit and quality improvement processes.
ANNP	Advanced Neonatal Nurse Practitioner.
Antenatal	Before the birth.
Antenatal Assessment Unit (AAU)	Antenatal Assessment Unit is part of the maternity unit at hospital where a woman attends for assessment and monitoring of the health of the mother and baby/babies. See also Triage.
APGAR score	An APGAR test is an assessment of a newborn baby's physical condition considering five factors: Appearance (skin colour), Pulse (heart rate), Grimace response (reflexes), Activity (muscle tone), Respiration (breathing rate and effort). Scores are recorded for each factor (0-10 with 10 as best).
Assisted/instrumental birth	When special instruments (forceps or ventouse) are used to help the baby to be born.
ATAIN	Avoiding Term Admissions Into Neonatal Units. This is a national programme of work launched by NHS Improvement in 2018 to identify harm leading to term admissions of babies.
AvMA	Action against Medical Accidents; a UK charity for patient safety and justice.
Badgernet	An electronic maternity healthcare record system.
BAPM	British Association of Perinatal Medicine.
Bereavement	In maternity and neonatal care, this can be as a result of miscarriage, stillbirth, the death of a newborn baby (perinatal or neonatal death) or the death of a mother (maternal death).
Birth partner	A birth partner is someone a woman chooses to have with them during labour and birth. They provide emotional and practical support and encouragement in addition to the health professionals providing clinical care. A birth partner may be a partner, family member or friend, or a professional birth partner such as a doula.
Birthrate Plus® / Birthrate+	The Birthrate Plus® workforce planning tool determines the required total midwifery workforce establishment for all hospital and community

	services and assesses real time staffing based on the clinical needs of women and babies for intrapartum and ward areas.
BMI	Body Mass Index (BMI) is a widely used measurement that helps assess whether an individual's weight is within a healthy range based on their height. It is calculated by dividing weight (in kilograms) by height (in metres squared – that is, height in metres multiplied by itself). The healthy range for an adult is typically between 18.5 and 24.9.
BSOTS	Birmingham Symptom-Specific Obstetric Triage System. BSOTs is designed to ensure that all women who contact Triage are assessed and treated based on clinical need. It sets the expectation that women attending a triage unit should be assessed within 15 minutes. A symptom-specific algorithm is used to assess a person's level of clinical risk which guides subsequent care and medical review.
Caesarean section	Birth of a baby through an incision made in the mother's abdomen and then into her uterus. It may be done as a planned (elective) or an emergency procedure.
CAVUHB	Cardiff and Vale University Health Board.
Cardiotocography (CTG)	Cardiotocography is a technique used to monitor the fetal heartbeat and uterine contractions during pregnancy and labour. The machine used to do this is called a cardiotocograph.
CD	Clinical Director.
CHANTS	Cymru inter-Hospital Acute Neonatal Transfer Service.
Clinical supervision	Clinical supervision is a formal process of professional support, reflection and learning that contributes to the individual development of health professionals.
CODAC	Causes Of Death and Associated Conditions is an internationally recognised classification system for recording causes of perinatal deaths. There are three levels within the CODAC classification system, with level 1 describing the primary cause of death and levels 2 and 3 describing more detailed associated conditions.
Congenital abnormality	Congenital anomalies are conditions present at delivery which originated before birth. They include structural, chromosomal and genetic anomalies. Screening during pregnancy can detect some congenital anomalies, while some are found at birth. Others are detected as a baby grows older. One in 50 babies is born with a congenital anomaly. This is the term used to described conditions such as cleft palate, spina bifida and Down's syndrome.
Continuity of care	Continuity and consistency of management and care including providing and sharing information and care planning and necessary coordination of care. For midwifery, this aims to provide a woman with care from the same midwife or team of midwives during pregnancy, birth and the early parenting period, as well as interdisciplinary care as needed.
Community midwife	A registered midwife who provides care for women in a community setting, including antenatal and postnatal care and home birth.

Complications	Problems that develop during pregnancy, labour and birth, or postnatally.
Confirmation bias	The tendency to interpret new evidence as confirmation of one's existing beliefs or theories.
Cooling	A therapy to cool a baby's brain and body temperature in a controlled environment to reduce the risk of permanent brain damage (see also HIE below). Why Was My Newborn Cooled? | Birth Injury Guide.
CPTSD	(Complex) post-traumatic stress disorder.
CQC	Care Quality Commission – the independent regulator of health and social care in England.
CT	Computed tomography scan.
CTMUHB	Cwm Taf Morgannwg University Health Board.
CYPWS	Children, Young People and Women's Services.
Datix	Datix is an electronic incident reporting and risk management system commonly used across the NHS to report incidents. It is also typically used to record complaints, claims, risks and safety alerts.
DFM	Decreased fetal movements.
DIC	Disseminated intravascular coagulation is a blood clotting disorder which can occur during pregnancy.
Doula	A **doula** is a non-medical professional who provides support to a woman during childbirth (and can be a woman's birth partner).
Duty of Candour	A statutory duty to make sure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong.
EMC	Enhanced maternal care.
Early Notification Scheme (ENS)	NHS Resolution's Early Notification Scheme in England investigates specific brain injuries at birth for the purposes of determining if negligence has caused the harm. To enable this, NHS providers in England must notify the ENS of maternity incidents which meet a certain clinical definition. There is no ENS in Wales.
Episiotomy	This is a procedure where a doctor or midwife may need to make a cut in the area between the vagina and anus (perineum) during childbirth. An episiotomy makes the opening of the vagina wider, allowing the baby to come through it more easily. Sometimes a woman's perineum may tear as their baby comes out. In some births, an episiotomy can help to prevent a severe tear or speed up delivery if the baby needs to be born quickly.
Extravasation	The accidental leakage of any liquid from a vein into the surrounding tissues when administering solutions such as medication or fluids.
Family	The people considered by the woman to be her family. This may include her partner, other children, relatives or close friends.
Family Integrated Care (FIC, FICare)	Family Integrated Care is a model of neonatal care which promotes a culture of partnership between families and staff. This enables parents

	to become confident, knowledgeable and independent primary caregivers.
FCVSG	Family and Community Voices Steering Group – a group set up for the Review to represent the voices of women and families.
Fetal Macrosomia	The term used for a baby who is larger than expected for gestational age; usually defined by an absolute weight (for example an estimated fetal weight of more than 3500g at 36 weeks) or in relation to centiles (for example, an estimated fetal weight above the 95th percentile on the growth chart at or after 36 weeks of gestation).
FFT	The Friends and Family Test.
First stage of labour	The time form when a woman is experiencing strong, regular contractions until she is fully dilated (10cms).
FGA	Fetal growth restriction is a condition where an unborn baby is smaller than expected for its gestational age due to not growing at a normal rate inside the womb.
FMU or MLU	Freestanding Midwifery Unit or Midwifery Led Unit. A facility offering care to women with straightforward pregnancies during labour and birth and in which midwives take primary professional responsibility for care. During labour and birth diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care, are not immediately available within the unit but can be co-located. In the event of obstetric or neonatal care being required, women/babies are transferred by ambulance to the obstetric or neonatal unit.
Forceps	A pair of hollow blades which are placed either side of the baby's head to assist with the birth.
GAP-Grow	Growth Assessment Protocol. This is a programme developed by the Perinatal Institute to improve antenatal detection of fetal growth restriction, the main risk factor for stillbirth.
Gestational age	The age of the baby in the womb, measured in weeks from the first day of the woman's last menstrual period. A baby is considered to be full term after 39 weeks. NICE guidance considers 37 weeks gestation as preterm and 41-42 weeks as post term (when an induction of labour would usually be offered).
Glucagon	A medication used to treat very low blood sugar levels.
GP	General Practitioner, a doctor who provides general medical treatment for people who live in a particular area.
Gynaecologist	A doctor who treats medical conditions and diseases that affect women and their reproductive organs.
Haemorrhage	Sudden and severe bleeding. In maternity, this is called an antepartum haemorrhage before birth and a postpartum haemorrhage after delivery.
HB	Health Board.
HDU	High Dependency Unit.
HEIW	Health Education and Improvement Wales is the strategic workforce body for the NHS in Wales.

HELLP	HELLP syndrome is considered to be a severe form of pre-eclampsia (sometimes called 'atypical pre-eclampsia') characterised by haemolysis (H), elevated liver enzymes (EL), and low platelets (LP).
HFOV	High frequency oscillatory ventilation is a treatment to provide respiratory support in neonates.
HIE	Hypoxic-ischaemic encephalopathy (HIE) is where a baby's supply of oxygen to the brain is interrupted during birth, for example due to a difficult birth. It can be fatal or cause permanent brain damage in severe cases. Cooling treatment to lower the baby's temperature may be offered if moderate or sever HIE is suspected.
HIW	Health Inspectorate Wales, the independent inspectorate and regulator of healthcare in Wales.
HoM	Head of Midwifery.
Home birth	Giving birth at home, with care provided by a midwife.
Hyperglycaemia	A condition characterised by high blood sugar levels.
Hyperinflation	Abnormalities found on a neonatal chest x-ray.
Hypocarbia	Reduced carbon dioxide in the blood.
Hypoglycaemia	A condition characterised by low blood sugar levels.
Hypotension	Abnormally low blood pressure.
Iatrogenic	Relating to illness caused by medical examination or treatment.
Inborn	A baby born in the hospital in which they receive their neonatal care.
Induction of labour (IOL)	A method of artificially or prematurely stimulating labour.
Infusate	A fluid given intravenously over a period of time for therapeutic purposes.
iNO	Inhaled nitric oxide is a therapy for neonates with respiratory distress.
Inotrope	A medication given to treat heart problems which alters the strength of the heart's contractions.
Intrapartum	The period from onset of labour through to delivery of a baby and placenta.
IPC	Infection prevention and control.
ITU	Intensive therapy unit (also known as intensive care unit).
Labour	The stages of labour and childbirth. The **latent stage** of labour is when the cervix starts to soften and dilate; **the first stage/established labour** is when the cervix has dilated to about 4cm and contractions are stronger and more regular; **the second stage** lasts from when the cervix is fully dilated until birth of a baby; the third stage happens after the baby is born, when the womb contracts and the placenta is delivered.
Language Line	Language Line is an on-demand interpretation service using live, professional interpreters via video link.
Late fetal loss	A stillbirth experienced from 22-23 completed weeks' gestation.

LHB	Local Health Board, e.g. SBUHB.
Lived experience	Direct first-person accounts of experience.
Llais	The independent statutory body for health and social care advocacy in Wales.
LSCS	Lower segment caesarean section: the most common form of caesarean section which involves a cut to the lower part of the uterus.
LSOA	Lower Layer Super Output Area (LSOA) is a small geographical area larger than a postcode area, but smaller than an electoral ward.
MAAW	Managing Attendance at Work.
The Maternity and Neonatal Safety Support Programme (MatNeoSSP)	The maternity and neonatal safety support programme is an initiative set up by the Welsh Government in 2022 to enable clear and consistent approaches to maternity and neonatal safety within all services in Wales. The key driver for the programme is to improve the safety, experience and outcomes of maternal and neonatal care.
Maternity journey	The woman's view of her journey from early pregnancy through to labour, birth, and the early days and weeks following birth.
Maternity pathway	The provision of care across the whole childbearing period from early pregnancy, pregnancy, labour, birth, postpartum and the early weeks of the baby's life. See also Maternity Journey.
Maternity Support Worker (MSW)	A Maternity Support Worker is an unregistered employee providing support to a maternity team, mothers, and their families. The MSW undertakes duties in a maternity setting for which midwifery training and registration are not required, under the direction and supervision of a registered midwife.
Maternity Voices Partnership (MVP)	Swansea Bay Maternity Voices Partnership (MVP) is an independent multi-disciplinary advisory and action team, working together to review and contribute to the development and continuous improvement of local maternity care. It is led by an independent lay Chair and Vice Chair, who ensure service users are represented.
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) is an academic collaboration (University of Oxford and University of Leicester) undertaking surveillance and reporting on maternal deaths and perinatal outcomes across the UK.
MEWS	Maternity Early Warning Score – a scoring system used by midwives and doctors to monitor the health of a pregnant women and identify signs of clinical deterioration. Typically, numerical weights are allocated to each measured vital sign.
MF	Modifiable Factor. Modifiable factors are events (or interventions) in care, which, had they been done differently may have made a difference in that care outcome.
Midwife	A midwife practising in the UK is a registered professional who has successfully completed a midwifery education programme meeting the Nursing and Midwifery Council's standards of proficiency for midwives.

	Midwives are fully accountable for their care and support of women and babies, and partners and families.
M&M	Morbidity and Mortality.
Monoamniotic twins	Monoamniotic twins are identical or semi-identical twins that share the same amniotic sac and placenta; also known as MoMo twins.
MRI	Magnetic resonance imaging is type of scan that uses radiology to provide detailed images of the inside of the body.
MSDS	Maternity Services Data Set. This is a routine set of performance statistics for maternity services produced by NHS Digital for England.
Multidisciplinary team (MDT)	A group of health and care staff who have different professional roles (and can be members of different organisations) who work together to make decisions regarding the treatment and care of patient.
MVP/MNVP	Maternity and Neonatal Voices Partnership. An MNVP listens to the experiences of women and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. By working with maternity and neonatal services providers, the MNVP influences improvements in the safety, quality, and experience of maternity and neonatal care.
Necrotising enterocolitis (NEC)	A serious gastrointestinal condition primarily affecting premature infants, characterised by inflammation and necrosis of the intestinal tissue.
Neonatal death	Defined by MBBRACE-UK as the death of a live born baby born from 20 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after birth.
Neonatal Intensive Care Unit (NICU)	A special or intensive care unit designed with special equipment to care for premature or seriously ill newborn babies. Neonatal care in the UK is organised into three types of unit: Level 1: Special Care Baby Unit (low dependency for babies who do not need intensive care), Level 2: Local Neonatal Unit (for babies who need a higher level of medical care) and Level 3: Neonatal Intensive Care Unit (for babies needing the highest level of medical care including very premature babies and those who are critically ill following birth).
Neonatologist	A doctor who specialises in caring for newborn babies.
NEWS	National Early Warning Score is a tool developed by the Royal College of Physicians to improve the detection and response to clinical deterioration in adult patients and is a key element of patient safety. NEWS2 is the latest version of the tool.
NHS	National Health Service.
NICE	National Institute for Health and Care Excellence, an independent organisation responsible for providing national guidance for health practitioners.
NIPEC	Newborn and Infant Physical Examination Cymru. The newborn and infant physical examination is offered to all babies in Wales. The main aims of the examination are to: Identify and refer all children born with

	congenital abnormalities of the eyes, heart, hips and (in males) testes, where these are detectable, within 72 hours of birth, to further identify those abnormalities that may become detectable by 6 weeks of age, at the physical infant examination and reduce morbidity and mortality. The NIPEC examination must be completed by a trained practitioner who is competent to undertake all elements of the newborn screening examination and who has undergone relevant training. This can be a midwife, nurse, health visitor, doctor, or physician associate.
NMC	The Nursing and Midwifery Council is the independent regulator in the UK for nurses, midwives, and nursing associates and sets standards for professional practice.
NNAP	National Neonatal Audit Programme.
NNU	Neonatal Unit which includes the Neonatal Intensive Care Unit (NICU).
NPEU	National Perinatal Epidemiology Unit is a multidisciplinary research unit based at the University of Oxford.
NPT	Neath Port Talbot.
NQM	Newly qualified midwife.
Obstetrician	A doctor specialising in the care of women during pregnancy and labour and after the birth. Obstetricians take primary professional responsibility for women with complications during labour and birth.
Obstetric Unit	A maternity unit within a hospital where doctors are available to provide medical care if needed; also referred to as the labour ward or delivery suite. Diagnostic and treatment medical services including obstetric, neonatal, and anaesthetic care are available on site.
OCRIM	Obstetric Clinical Risk Meeting.
ONS	Office for National Statistics.
Outborn	Babies born in other hospitals to where they receive their neonatal intensive care.
PADR	Performance appraisal and development review.
Paramedic	A healthcare professional trained to respond to medical emergencies in the community and during transport to hospital.
Parity	The number of previous live births to a woman.
Partogram	The partogram is a graphical analysis monitoring maternal and fetal wellbeing during the active phase of labour. Relevant measurements might include cervical dilation, fetal heart rate, duration of labour and vital signs.
Peeps	A UK charity dedicated to those affected by hypoxic-ischaemic encephalopathy (HIE).
Perinatal	The time shortly before and a few weeks after the birth of a baby.
Perinatal mortality	Defined by MBBRACE-UK, perinatal mortality refers to baby deaths, antenatally or intrapartum, from 24 completed weeks' gestation; it also

	incorporates neonatal deaths, occurring within the first 28 days after an infant is liveborn. See also late fetal loss.
Perinatal mental health	Refers to a woman's mental health and wellbeing; problems can occur during pregnancy or in the first year following the birth of a child.
Perineal tear	A laceration to the woman's perineum during childbirth, which is the area between the vagina and anus. Small lacerations can heal naturally but may require stitches.
PMRT	Perinatal Mortality Review Tool. A national method for the review of care received by women and babies who died in pregnancy from 22 weeks' gestation onwards or died within 28 days of being born (perinatal deaths). Developed by a collaboration co-led by Oxford Population Health's National Perinatal Epidemiology Unit.
Postnatal care	Maternity care for women and babies from the birth until about eight weeks afterwards. Once at home, support is provided by community midwives and health visitors to check that both mother and baby are well.
Postpartum/ postnatal	The period beginning immediately after the birth of a baby until about six to eight weeks after the birth.
PRAMS	Parental Resilience and Mutual Support service.
Premature birth/preterm birth	The birth of a baby before the 37th week of pregnancy.
PROMPT	Practical Obstetric Multi-Professional Training.
Prophylaxis	Treatment given to prevent disease or harm.
PSIRF	The Patient Safety Incident Response Framework (PSIRF) sets out NHS England's current approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. It is mandatory in England for services provided under an NHS standard contract.
Putting Things Right	The process for raising concerns or complaints in the NHS in Wales.
QIS	Qualified in Specialty.
RCM	The Royal College of Midwives is the professional association and trade union for midwives and maternity support workers in the UK.
RCOG	Royal College of Obstetricians and Gynaecologists is the professional body who oversee the medical education, training and examination of obstetricians and gynaecologists in the UK.
RCPCH	Royal College of Paediatrics and Child Health is the professional body for paediatricians in the United Kingdom.
Robson Group	The Robson Group system classifies caesarean sections into ten groups on the basis of previous obstetric history (parity, previous caesarean section), onset of labour, number of fetuses, fetal presentation and gestational age. This system is increasingly used to monitor and compare rates of caesarean section and was recommended for use by the World Health Organisation in 2015.

Serious adverse incident	Any event or circumstance that led or could have led to unintended or unexpected harm, loss, or damage.
Sands	Sands is a leading charity in the UK providing support to those affected by the death of a baby, before, during or shortly after birth. Sands works in partnership with health care professionals, Trusts and Health Boards and offers a range of training programmes and bereavement care resources to families.
SBUHB	Swansea Bay University Health Board.
SCBU	Special Care Baby Unit; a Level 1 NICU (see above).
Screening	A test or set of tests to check for a condition in a person who shows no symptoms.
SEIPS	Systems Engineering Initiative for Patient Safety is a framework for investigating incidents which focuses on system relationships and interactions.
SGA	Small for gestational age refers to newborns who are smaller in size than normal for their gestation.
Shoulder dystocia	A complication during the birth when the baby's head has been born but one of the shoulders becomes lodged behind the mother's pelvic bone preventing the birth of the baby's body. If this happens, extra help is usually needed to release the baby's shoulder. In the majority of cases, the baby will be born promptly and safely.
Skin-to-skin contact	Skin-to-skin contact is the practice where a baby is dried and laid directly on the mother's bare chest after birth, both of them covered in a warm blanket and left for at least an hour or until after the first feed. It can help to boost a mother's milk supply. Skin-to-skin contact is vital in neonatal units where it is often known as 'kangaroo care.' It helps parents bond with their baby and supports better physical and developmental outcomes for the baby.
Socio-economic	Socio-demographic factors refer to the characteristics of a population group such as age, income, education, ethnicity and area of residence.
Spontaneous vaginal birth	The birth of a baby through the vaginal canal without instrumental intervention; also known as a physiological birth.
STAT	STAT is a medical abbreviation that means immediately or without delay.
StatsWales	Health and care national statistics provided by the Welsh Government
Stillbirth	MBRRACE-UK defines as stillbirth as a baby is born from 24 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
Third/fourth degree tear	A laceration that occurs during childbirth. A third-degree tear is a tear that extends into the muscle that controls the anus (the anal sphincter). If the tear extends further into the lining of the anus or rectum it is known as a fourth-degree tear.
ToR	Terms of Reference.

Transitional care	Transitional care means 'in between care' and is for babies who need a little more nursing care and monitoring than the routine care that all babies receive on the maternity ward. It supports babies to stay with their mother rather than going to the Special Care Baby Unit.
Triage	Maternity triage provides the primary point of contact for advice, assessment and prioritisation in terms of next steps for women who have concerns or are experiencing an emergency during their pregnancy, labour or shortly after birth. Triage can also be contacted by telephone for advice and support.
Trimester	A three-month period of time. Pregnancy is divided into three trimesters: first trimester – up to around 13 weeks; second trimester – to around 26 weeks; third trimester to term.
UCAS	Universities and Colleges Admissions Service.
Uterine atony	Lack of tone in the uterus is the most common cause of postpartum haemorrhage. This emergency condition occurs when the muscles of the uterus fail to contract sufficiently following delivery of a baby and so bleeding continues.
VON	The Vermont Oxford Network is a voluntary collaboration of health care professionals working together as an interdisciplinary community to change the landscape of neonatal care.
Welsh Risk Pool	The Welsh Risk Pool is part of the NHS Shared Service Partnership Legal and Risk service. It provides the means by which Health Boards in Wales are able to indemnify against risk.
WIMD	Welsh Index of Multiple Deprivation.
Woman/women	This reflects the biology and identity of the great majority of those who are childbearing. These terms include adolescent girls. They also include people whose gender identity does not correspond with their birth sex or who may have a non-binary or fluid identity.
WTE/FTE	Whole time equivalent (or full time equivalent) is a unit of measurement to express the number of employees based on their contracted hours.

Appendix 3 – Summary of actions arising from HIW inspections

Below is a detailed summary of how actions arising from the HIW visits in 2023 and 2024 have been delivered, sustained and assessed. The Health Board agreed all actions were complete in March 2025. We have reviewed the Health Board's progress against the actions arising from the HIW visits. We have provided an aggregated assurance rating for each action, and a summary of findings to support the assurance rating given. We have used the following assurance definitions:

Rating	Levels of assurance
Full	Action has been delivered, and outcomes continue to be monitored to ensure any impact is sustained.
Reasonable	Significant action taken but outcomes have not yet been tested and assured.
Limited	Some action taken but further work is required, and outcomes have not yet been identified or assured.
Weak	There are concerns about the delivery of action.

Improvement	Commentary	Status
2024 HIW Inspection: Immediate improvement plan		
Antenatal Assessment Unit (AAU): The Health Board must ensure that telephone information is taken by a clinically trained member of staff. The Health Board must increase staffing of the antenatal assessment unit to ensure sufficient numbers and skill mix of staff are in place. The Health Board must update and communicate an effective staff escalation process for all staff members working within AAU.	We found evidence that there is more work to do to be assured that women receive the appropriate advice when calling the unit. The implementation of BSOTS and corresponding changes made to dedicated clinical staff in this area should address the improvement, however more work is needed to assess its impact to date.	
2024 HIW Inspection: Improvement plan		
Patient experience: The Health Board should review and address the feedback from women and families.	Identified as complete in April 2025 (notably after the full action plan was closed), work in this area remains under development. The Patient Experience Midwife has been appointed but is not yet in post. There are many ways in which services are starting to strengthen the way they respond to feedback from women and families, but overall this work is in its infancy.	
Communication and language: The Health Board should review and improve the provision of Welsh language display information in line with the active offer. The	Feedback from women and families for whom English is not their preferred language indicates that there is more to do to ensure that information provided is accessible to all. We noted during site	

Improvement	Commentary	Status
Health Board should consider additional information displays in other languages.	visits that there were examples of information provided in Welsh but not in any other languages.	
Bereavement care: The Health Board must review and improve bereavement facilities and support for women, families, and midwives. In addition, the bereavement provision should be reviewed with a view to making the room more homely. The Health Board should improve bereavement training provision for midwives.	Steps have been taken to improve the bereavement facilities; however, training provision has not yet been extended. Whilst the skills and impact of the Specialist Midwife for Bereavement were frequently referenced by those we spoke to; concerns were also raised about capacity and over-reliance on one individual.	
Patient choice: The Health Board must ensure that discussions around birth plans /choices for labour and birth are held and routinely recorded in patient notes during the antenatal period.	We heard that all staff have been briefed on the importance of capturing discussions around birth choice. We have not seen evidence that the service has assessed the impact of this briefing or whether further action is needed.	
Patient records: The Health Board must ensure that: • Staff are reminded of the need to sign all relevant documents and ensure that the signature is legible. • Regular documentation audits are conducted and learning takes place from the findings.	The importance of complete documentation has been communicated via various routes to staff. We have seen a draft audit plan for 2025/6 which includes a maternity record keeping audit.	
Antenatal capacity: The Health Board must continue to mitigate the risks of not following national guidance regarding antenatal scanning for fetal growth as well as providing plans to increase capacity for scanning.	The action was marked complete in late 2024. Action taken includes: • 3-weekly scanning in line with GAP-Grow following a pilot in October 2024; • implementation of midwifery sonography at Neath Port Talbot; and • improved GAP-Grow training compliance for midwifes and obstetricians. The service risk register contains a linked risk; the score has reduced considering the above actions, but the risk will continue to be monitored at risk meetings.	

Improvement	Commentary	Status
Risk management: The Health Board must review and update the escalation policy to include a formal staffing escalation process and share details of how they will ensure that this process is followed.	The escalation policy has been reviewed and updated to provide more clarity about staffing in times of high acuity. We saw limited evidence of steps taken to assess whether staff are aware of the policy or how the policy has been enacted in practice.	
Obstetric theatres: The Health Board must finalise, date and communicate the Standard Operating Procedure related to the use of the second obstetric theatre.	A standard operating procedure has been drafted and ratified. Some theatre staff, however, raised concerns during site visits about the ability to safely staff a second theatre if needed.	
Infection prevention and control (IPC): Some women on the labour ward were seen carrying urine through the ward from the toilet. The Health Board should review this process to ensure that IPC risks are minimised.	We understand that the intrapartum lead midwife has reviewed the process of urine sampling and communicated changes to staff. We have also been told that this has been a consideration when senior leaders visit the ward	
Incidents: The Health Board should continue their work to reduce the backlog of open Datix incidents in a timely manner and monitor progress.	Work in this area is ongoing, but progress can be evidenced in that the backlog of incidents has reduced. In May 2025, all incidents that related to 2023 were closed. This has been achieved via: • Monthly maternity incident sprint sessions to close a selection of incidents simultaneously. • Increased frequency of ATAIN meetings. • Weekly incident meetings focusing on the closure of overdue incidents. There is visibility of the oldest incidents and the reasons that they are still open at key meetings, such as Enhanced Monitoring.	
Leadership: The Health Board should review and improve feedback mechanisms for staff to feedback on the leadership team.	The staff survey undertaken as part of this review was broadly positive about the extent to which leaders are visible, approachable and responsive to feedback. This was further supported by feedback during interviews, focus groups and site visits. Café conversations have been introduced to allow staff to share feedback in an informal setting with key leaders and a staff experience, wellbeing and retention	

Improvement	Commentary	Status
	plan is being developed which includes mechanisms to capture staff feedback. A new staff newsletter was developed in November 2024 which included reference to the ways in which staff can provide feedback. We understand that the newsletter will be published on a frequent basis, however we have not seen evidence of this.	
Medical equipment: The Health Board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment.	We understand that an asset log has been developed, and critical equipment issues are monitored via service-level risk registers. We have seen evidence of urgent safety briefs being issued to all staff on issues such as stocking of emergency trolleys. Incident analysis undertaken in the last six months shows the proportion of newly reported incidents that related to equipment and devices, which is typically around 2%, or 1-2 incidents per month. We have not seen evidence that staff have been asked whether access to equipment has improved consequently. The survey administered as part of this review found that over 30% disagreed with the statement "I have the right equipment and facilities to deliver safe care."	
Medicine storage: The Health Board must review medicine storage on the delivery unit to ensure that all storage for medicines complies with the medicines management policy.	Medicine storage has been reviewed by the labour ward team; however we saw no evidence of steps taken to be assured that the medicines management policy is now complied with.	
HIW patient feedback: The Health Board should monitor, review and act upon feedback in relation to delays related to pain medication.	We understand that self-administration of medicines has been reintroduced to inpatient areas, however we did not see evidence of systematic steps taken to monitor, review and act upon feedback more broadly in relation to pain medication. As outlined in section 3, timely access to pain medication is a recurring concern raised by women.	
Quality of management and leadership: The Health Board should reflect on the HIW staff survey findings (four out of 60 staff felt they had faced discrimination at work in the	As referenced above, steps have been taken to strengthen mechanisms for staff to share feedback, and this is being	

Improvement	Commentary	Status
last 12 months) and make attempts to further explore and identify staff discrimination and ensure that appropriate action is taken to prevent any further discrimination. The Health Board must improve mechanisms to support the effective performance management of staff.	incorporated into a staff experience, wellbeing and retention plan. Staff survey results in this area are broadly positive with particular highlights being: • 71% maternity staff felt supported by department managers; • 73% agree that their line manager treats everyone equally; The service needs to be alert to the perception of cliques and favourites in departments, a concern raised by over 50% of survey respondents. Whilst we were told that this was a consideration in Café Conversations, we did not hear of plans to frequently and systematically survey staff which may be a consideration for the service given feedback here and in the context of the wider findings in section 5.	
Maternity dashboard/scorecard monitoring: The Health Board should communicate developments in relation to the dashboard and scorecard monitoring of the unit to improve transparency and communication.	A perinatal dashboard is in the process of being developed and is due to be launched in Summer 2025. This will provide an 'early warning' for a range of quality metrics. Further findings in relation to the scorecard and reporting in more detail are outlined in section 7.	
Staffing levels: The Health Board must monitor and improve levels and skill mix of staff in all areas of the unit to ensure safe and effective care can be delivered, patient experience is positive, and staff wellbeing is protected. The Health Board must review staffing levels in the Transitional Care Unit to ensure the right number and type of staff are in place and suitably trained in place in line with BAPM guidance.	Skill mix was a concern raised throughout our review from staff in both services. This is monitored operationally via a range of mechanisms, central to which is a daily Safety Huddle. The lack of dedicated staff in Triage was a key concern until the launch of BSOTS in late 2024. We have heard that this has improved, however there remains the need to evaluate the overall impact of BSOTS on safety, quality, and experience. Transitional care was also raised as a concern to us; we have been told that a task and finish group has been established with staff from both services in order to consider the current model and alternative models such as neonatal outreach, with a view to developing proposals for the service.	

Improvement	Commentary	Status
Annual appraisal compliance: The Health Board must share plans to improve compliance with performance appraisal and development reviews (PADR).	Rates increasing for completion of performance appraisal and development reviews.	
Mandatory training compliance: The Health Board should consider improving the way in which mandatory training compliance is monitored and reported.	Mandatory training compliance rates are increasing.	
People engagement, feedback and learning: The Health Board should introduce mechanisms / processes to engage with staff feedback. To monitor, review and act on themes that emerge and to improve staff satisfaction.	See narrative above (under Leadership) regarding the current lack of mechanisms to monitor staff engagement on a systematic, rolling basis.	
Wisdom guidelines: The Health Board should share plans to ensure that Wisdom guidelines are reviewed, updated and communicated in a timely manner.	In progress.	

Appendix 4 – Current departmental resource pressures

Areas of potential under-capacity	What did staff tell us?	How is this being addressed?
Triage	Having staff dedicated to triage is central to the success of BSOTS. We heard that this is not always possible. Sufficient registrar cover for BSOTS was a concern raised by many we spoke to.	BSOTS was introduced in November 2024 and the service is in the process of collecting data to assess staffing configuration. This work is essential to ensuring that Triage functions effectively by having specialist staff who can provide emergency care to women.
Community midwifery	We heard a range of opinions about whether there is sufficient community capacity with several staff voicing their concerns that they are unable to provide continuity of care, as well as provide the requisite quality of care to women in the community.	The service has recently trialled different shift patterns (such as 12-hour shifts) in response to staff feedback gathered via a questionnaire. There is a pressing need to more thoroughly understand capacity and demand in community settings.
Specialist midwives	We repeatedly heard calls for more specialist midwife capacity, particularly in relation to bereavement, mental health and diabetes.	There are some Band 6 midwives with skills and expertise in specialist areas, such as mental health. The service is looking at ways to maximise their input, in order to support the senior specialist midwives, aid succession planning and enhance the resilience of such services. As outlined above, thoroughly understanding the current and projected demand for specialist input is a critical next step. Specifically, concerns were raised that the inclusion of specialist staff in clinical care establishment calculations undertaken by BirthRate+ negates the impact that specialist roles can have on additional support women need.
Newborn and Infant Physical Examination Cymru (NIPEC)	We heard that there is a lack of confidence from some newly qualified midwives to undertake NIPEC assessments. The result is that women who do not give birth at Singleton Hospital may need to attend in the days after giving birth for this assessment, rather than it being done	We did not see evidence of steps to address this.

	at home or at Neath Port Talbot Birth Centre.	
Transitional care	Repeated concerns were raised about the staffing model for transitional care beds on the postnatal ward. There is a daily ward round from a neonatal registrar, however no neonatal nursing outreach. The skills of nursery nurses working in this area were praised, however the acuity of some babies and lack of nursing support was noted by many we spoke to.	A transitional care working group has been established with representation from the maternity and neonatal teams. We understand that this work is in its infancy but aims to evaluate the current service and make recommendations regarding future configuration, including neonatal nursing outreach.
Breastfeeding support	Staff and women alike recognised that breastfeeding support is not sufficient.	This is referenced in the recently published Quality Statement for Maternity and Neonatal Services in Wales and the Health Board and has plans for further detail to be set out in service specifications.
Ward management	The real impact of workload was questioned repeatedly with pressures of annual leave, sickness, management of shifts and roster population. The fact that these roles are fundamental to the delivery of improvement initiatives was highlighted as a key risk "hard to operationalise improvement when under so much pressure." Staff described trying to deal with a range of management issues while also being pulled into clinical work.	We did not hear of any planned work to address the workload of ward managers.
Antenatal scanning	Midwifery sonography capacity has been a long-standing challenge for the Health Board with concerns about training compliance exacerbating the risk in this area.	Significant effort has been made to ensure staff are compliant with GAP Grow training to increase the frequency of growth scanning in the third trimester. This was, however, raised as a concern by the Welsh Government in May 2025 as current data indicates that only 50% of babies born below the 10th centile are identified. This suggests that further work is required to ensure that the overall capacity for sonography is sufficient.
Medical workforce	Job planning reviews for the medical workforce are underway; however we were frequently told that there is insufficient time allocated in job plans	This work is progressing and is being led by the Clinical Director; it is expected to conclude in late 2025.

	for roles such as governance, improvement, and audit, including ATAIN.	
Psychological support for staff, women and families	This was a recurring area of concern amongst staff in both services. We heard from staff, women and families alike that the demand for psychological support outstrips capacity. Both services are 'trauma-saturated' environments to work in. Maternity has no dedicated psychological support. Since October 2024, the neonatal department has had input from a clinical psychologist on a 0.5 WTE basis. Women and families need psychological support relating to bonding, adjustment, trauma, and loss. There is also the risk that staff being unable to meet the needs of those they are responsible for caring for further compounds their own stress and distress, resulting in moral injury.	There was consistent recognition from senior leaders that psychological support is lacking across the perinatal pathway. Barriers to addressing this gap were identified as the Health Board's constrained financial position and the ability to recruit into such posts. We have referenced the need for trauma-informed training in section 6.
Allied Health Professional (AHP) support	There are a number of areas in which the Health Board has unsuccessfully tried to recruit to AHP roles, such as dietetics.	We understand that there are embryonic discussions with other Health Boards also struggling with AHP capacity about roles that could be commissioned to work across the network.
Radiology	Paediatric radiology expertise has been a weakness since 2018. In the intervening years, the service has relied on the part-time support of a semi-retired, highly experienced specialist, although this arrangement is unsustainable.	The risk and the effectiveness of risk management in this area is explored further in section 7 of the report.

Appendix 5 – Assessment against the Quality Statement for Maternity and Neonatal Services in Wales (2025)

Quality Statement standard	Summary of SBUHB position
Safe	
1. Consistent use of person-centred, evidence-based pathways of care, delivered by a skilled, multiprofessional workforce, supported by robust clinical governance arrangements and escalation pathways from ward to Board.	**Good and improving practice** • Examples of excellent person-centred care, particularly where there is continuity of care and the involvement of specialist midwives. **Gaps** • Further work is needed to ensure consistent person-centred care is provided, particularly in relation to delayed induction of labour and planned caesarean sections. • The capacity of specialist midwives is limited and there are barriers to providing breastfeeding support. • Governance arrangements need to mature further to effectively triangulate issues and ensure a person-centred response. • Pathways of care need further development.
2. Risk held within the service is systematically assessed, communicated and escalated within the organisation as well as through national governance systems, with appropriate measures taken to proactively reduce the potential for harm.	**Good and improving practice** • Oversight of risk receives detailed scrutiny via the Enhanced Monitoring governance process. **Gaps** • Risk registers are not shared with all managers. Doing so would strengthen collective understanding and accuracy about the status of actions and mitigating action. • The 'line of sight' from Board to service level on risks would benefit from greater clarity. • We identified risks which have not been formally recognised, including the lack of neonatal radiology expertise and external validation; and the use of transitional care beds on the postnatal ward to care for premature babies with limited input from neonatal nurses.

3. Systematic monitoring of demand and capacity information to inform service design and configuration, with consideration of acuity, complexity and specialist requirements to enable delivery in line with agreed national standards and recommended staffing ratios.	**Gaps** • Birthrate+ assessment has not been undertaken since 2023. • Analysis of the impact of reopening the intrapartum care pathway in September and October 2024, and the introduction of BSOTs in October 2024, has not yet been undertaken, although the service intends to do this in Summer 2025. • Community midwifery staff reported that caseloads are very high and risk compromising continuity of care and a person-centred approach.
Timely	
4. Systems and processes are in place for effective multi-professional and multi-agency communication across perinatal services to deliver care in the most appropriate place and time.	**Good and improving practice** • There are positive working relationships across staff groups and professions working in perinatal services. • Work is underway to strengthen perinatal governance structures to better support systematic collaboration across the perinatal pathway. **Gaps** • Workloads and capacity, particularly for the obstetric workforce, is a barrier to a consistent multi-professional approach to governance, improvement, and training. • The reliance on midwives and nursery nurses on the postnatal ward to care for premature babies in transitional care beds with limited input from neonatal nurses is a risk.
5. Timely, robust and evidence-based assessment is undertaken for all aspects of perinatal care in line with agreed protocols, overseen by skilled and experienced professionals to enable effective decision-making and clinical prioritisation.	**Good and improving practice** • The implementation of BSOTs should strengthen the timeliness and effectiveness of care and clinical prioritisation. • Significant investment in staffing in both services in 2024 is widely seen a positive step to delivering improved clinical assessment. **Gaps** • Skill mix is a challenge in both services due to the high number of newly qualified staff, coupled with the loss of highly experienced staff in the years since Covid-19. • Guideline governance needs to be strengthened in both services. • Timeliness of care is a concern in relation to delayed induction of labour, although work is ongoing in the Health Board to improve this.
Effective	
6. Universal care pathways are autonomously provided by	**Good and improving practice**

midwives to ensure a holistic approach to care, with additionality depending on the level of complexity. Women receive dedicated support from the same midwifery team throughout their pregnancy in line with the continuity of carer model.	• All-Wales clinical pathways are in place with input from specialist midwives. • Community midwifery teams have been structured to strengthen the delivery of continuity of care. **Gaps** • Perinatal mental health pathway. • Shift patterns in community teams are under review in order to ensure they best support continuity of care for women.
7. Standardised reporting and multiprofessional perinatal investigation for adverse events is undertaken, with effective local and national processes in place to share learning, implement changes and reduce the risk of future harm. Openness and transparency are demonstrated in line with the duty of candour, and women, parents and families are involved throughout the investigation process.	**Good and improving practice** • There are dedicated teams in both services to undertake investigations and ATAIN reviews, however there is not yet a consistent approach to combined multi-professional reviews. **Gaps** • There are long delays in sharing responses to concerns and investigation reports, coupled with improvements needed in the way learning is analysed and shared. • Further improvement is needed to meaningfully involve women and families in responses to adverse events and concerns and correspond openly, compassionately and directly.
8. Robust population health strategies are in place to promote health and wellbeing with a focus on prevention, supported by processes for providing guidance, advice and support. There are effective mechanisms for capturing, monitoring and evaluating population health data to inform quality improvement initiatives.	**Good and improving practice** • Outcome measures are captured including smoking cessation rates and breastfeeding rates at discharge from maternity care and at 28 days postnatally. Uptake of contraception following birth is also captured. **Gaps** • There is an intention to establish a Perinatal Population Health Steering Group.
Efficient	
9. Available resources are used efficiently and sustainably with a view to minimising environmental impact, whilst maintaining a clear focus on delivering person-centred care to maximise outcomes and experiences.	**Good and improving practice** • The risk assessment at booking is aligned to widely accepted good practice and allows for the early identification of specialist support. **Gaps** • Staff shared their appetite to have more opportunities to share ideas to improve efficiency and flow. For example, we heard that when women who have recently given birth and their baby is admitted to NICU, on-site access to postnatal checks is not available.

Equitable	
10. Care and treatment are determined by clinical priority and delivered in an equitable way, understanding any additional care needs, with a clear focus on avoiding unnecessary variation and intervention.	**Good and improving practice** • Family Integrated Care (FIC) was highlighted by women, families and staff as a core strength of the neonatal service. • BSOTs implementation should address unnecessary variation in Triage, coupled with the introduction of Access Cards (see further below). **Gaps** • There is a need to ensure staff are supported to have insight into the needs of women and families from seldom-heard groups.
11. Women, parents and families are enabled to communicate in the language and method of choice to meet their individual needs, with the Welsh language actively offered.	**Good and improving practice** • A recent quality improvement initiative in maternity centred on the use of Access Cards for women who do not feel comfortable or able to communicate effectively via telephone. These give direct face-to-face access to triage. **Gaps** • Language Line is available for women and families for whom English is not their preferred language, however we heard a number of experiences of women who had delayed access to Language Line, and those who continued to receive correspondence not in their preferred language. • Communication preferences following an adverse event or concern are not routinely considered.
12. Protected characteristics, social and cultural backgrounds and additional care needs are recognised as integral to providing accessible, equitable and person-centred perinatal services.	**Gaps** • Whilst we heard several positive accounts from women and families that staff went "above and beyond" to provide person-centred care, women told us that there is further work to do to support staff to understand different cultural needs and approaches. **Good and improving practice** • Jig-so is an early intervention service set up three years ago and has a dedicated team of predominantly midwives but also nursery nurses and speech and language therapists. Initially, the initiative was for young expectant parents aged 16-24 but was expanded around 18 months ago to include anyone who may need additional support. Women who might benefit from the service are identified at booking and referred, or they can be referred by a social worker who may already be in contact with the family. In early 2025, there was reference to seeking additional capacity for this service. • In recent months, the question: *"are you working with social services or ever been known to social services"* has been added to the pregnancy registration form with a view to recognising women's additional support needs before

	booking; this assists in the effective management of caseloads and provides early intervention.
13. Equitable access to physical and mental health advice, support and treatment throughout the perinatal journey regardless of geographical area, recognising this care may not be provided within the Health Board of residence.	**Good and improving practice** • There is a range of birth options provided by SBUHB (two midwifery-led birth centres, homebirth and consultant-led care). Many staff told us of their shared commitment to providing women with choice. • Transitional care (but lack of neonatal nursing outreach). **Gaps** • Lack of specialist midwives. • Support for mental health care needs. • There were examples of cases via Triage where the distance between the maternity unit and home (often around an hour's travelling time) is not considered while woman is in the latent phase.
Person-centred	
14. Appropriate and timely information is provided in multiple languages and formats, and women are supported to make informed decisions throughout their pregnancy, birth planning, birth and the postnatal period. A range of birth settings are available including hospital, birth centre and home birth.	**Good and improving practice** • See above commentary regarding a range of birthing options for women, Language Line and Access Cards. • The Health Board's website has a wide range of information pertaining to pregnancy, birth and postnatal care. **Gaps** • Feedback from women and families from seldom heard groups indicates a need to consider how staff can be confident that information shared reaches women and is understood in order to fully enable women to make informed decisions. • A recurring theme in feedback from women and families is the need for improved antenatal education in order to ensure there is sufficient insight into the different paths that birth can follow. • See above comments regarding access to language support.
15. Healthcare professionals respect and support the autonomy of women as decision-makers regarding their own care, and ensure they are made aware of their rights around consent.	**Good and improving practice** • See above commentary regarding a range of birthing options for women. **Gaps** • Feedback from women included stories of women not feeling sufficiently involved in decisions about their own care.
16. Unnecessary separation of mothers and babies should be avoided with transitional care provision consistently available.	**Gaps** • The HB is not commissioned to operate a neonatal outreach service in traditional care. Band 4 nursery nurses are the predominant care givers for premature babies needing

	enhanced care. Whilst the competence and skills of the nursery nurses was repeatedly highlighted, there should be neonatal nurse outreach in place for qualified neonatal expertise to oversee the nursery nurses on the ward. The risk is currently partly mitigated by doctor cover from neonates.
17. Parents are supported and empowered to be primary care givers and viewed as equal partners in all aspects of their baby's care. A family integrated care model will be facilitated whilst babies are on the neonatal unit.	**Good and improving practice** • The FIC approach is well-established in neonates and was frequently cited by parents and staff as a significant strength. Staff at all levels and in all professions advocated the benefits of the FIC model.
18. The All-Wales perinatal engagement framework is implemented to ensure the ideas, feedback and concerns of women, parents and families are heard and acted upon, with consistent use of person-reported experience measures, real-time engagement and co-production methods. This data is routinely triangulated with other insights, quality metrics and outcome measures.	**Gaps** • The HB intends to undertake a gap analysis against the perinatal engagement framework during Spring and Summer 2025. • There is scope to strengthen the engagement between the Maternity Voices Partnership and ward managers.
19. Women are supported with their chosen method of feeding and receive the information and guidance required. Breastfeeding is promoted to help to reduce broader health inequalities and contribute to it being viewed as a culturally accepted norm across Wales.	**Good and improving practice** • There is a breastfeeding meeting which is held jointly with staff from maternity and neonates. There is also positive operational collaboration between infant feeding leads in maternity and neonates. • Service leaders were described as supportive ambassadors for the infant feeding agenda. **Gaps** • Women and families told us that breastfeeding support was not always available due to the capacity of staff. This was echoed by several community staff we spoke to.
20. The national bereavement care pathways are implemented to ensure equitable access to bereavement care and support for women, parents and families who have experienced death of a baby during pregnancy, birth or in the neonatal period, regardless of their geographical area	**Good and improving practice** • The Bereavement Specialist Midwife was repeatedly highlighted by women, families and colleagues as an asset to the service. **Gaps** • Capacity is constrained and the maternity service currently relies on one individual to provide specialist support. • The bereavement room facility requires improvement.

21. Compassionate and inclusive leadership is demonstrated, enabling transformative change in a coordinated way from ward to board, supported by clear lines of communication and escalation, with a named executive board member responsible for perinatal services.	**Good and improving practice** • Matrons and managers in the service clearly demonstrated compassionate and inclusive leadership. **Gaps** • Not all staff would know who the named Executive is for maternity services.
22. Robust succession planning is in place for existing and future leaders, with equity of access to developmental opportunities.	**Good and improving practice** • Evidence positive in this regard for the neonatal medical workforce. • Staff did not voice concerns that development opportunities are unequitable. **Gaps** • Reliance on the Clinical Director for Maternity who is a potential single point of failure when absent from role.
23. The national strategic perinatal workforce plan is implemented, ensuring appropriate multiprofessional staffing across services. Workforce information is readily available and used to support optimal staffing and planning.	The Strategic Perinatal Workforce Plan for Wales was approved by Health Education and Improvement Wales (HEIW) in April 2025 and is to be launched imminently (see report section 6).
24. The workforce undertakes multiprofessional training and has access to service-specific programmes of continuing professional development to ensure skills are maintained and further developed, as well as aid workforce retention and career progression.	**Good and improving practice** • Appropriate training in place with good engagement from the midwifery team and Practice Development Manager. **Gaps** • Some lack of engagement from obstetric and anaesthetic team colleagues.
Culture	
25. Perinatal services promote a culture which embodies compassion, empathy kindness and allyship, with these values and behaviours actively embraced and demonstrated by all members of the workforce.	**Good and improving practice** • Significant culture work has been underway with leaders increasingly exhibiting role model behaviours.
26. The health, wellbeing and safety of staff is prioritised at all levels of the organisation. Psychological safety is embedded and timely	**Good and improving practice** • No issues were highlighted. Psychological safety is observable with good confidence expressed by staff.

support is available to understood and meet the needs of the workforce.	
27. A just, learning and improvement culture is fully embedded in line with service and organisational values and behaviours, and staff at all levels are supported and actively encouraged to raise any concerns in line with the speaking up safely framework.	**Good and improving practice** • In general, staff spoke positively about feeling psychologically safe to raise concerns. **Gaps** • There is an insufficiently explicit link between safety intelligence and each services' improvement priorities. • Staff also felt that learning could be more systematically shared and in a timelier fashion.
28. An intelligent suite of nationally agreed process, experience and outcome measures is systematically captured and regularly scrutinised by clinical, managerial and executive teams, with appropriate escalation and actions taken aligned to local and national assurance and improvement mechanisms.	**Good and improving practice** • This has been a material gap; however a Maternity and Neonatal dashboard is currently being introduced. **Gaps** • There are no experience measures in the current data set. • There is no document gathering all the national requirements in an action plan for maternity services.
29. Integrated perinatal digital clinical systems are adopted to inform a single national dataset and enable delivery of safe, high-quality and consistent services where data is available to support shared decision-making, inform service delivery, drive improvements and contribute to safe and person-centred care.	**Gaps** • A manual system is used at present but Badgernet expected to be implemented in Autumn 2025 • Currently utilising the Health Boards electronic patient record system to record discussions between midwives and women when they call triage.
30. Women, parents, families and staff are encouraged and supported to participate in local and national perinatal research to advance knowledge and improve care, experiences and outcomes.	**Good and improving practice** • Evidenced in neonatal services **Gaps** • Not yet in place in maternity services.
31. The workforce is actively engaged in delivering evidence-based local and national quality improvement initiatives which are informed by feedback from women, parents and families, as well as insights from national bodies and audit programmes,	**Good and improving practice** • There is a draft perinatal audit plan for 2025/26. • A quality improvement initiative is underway as a result of feedback from complaints regarding induction of labour. • Other work is underway as a result of feedback from women and families, for example letters to families, BSOTS and postpartum haemorrhage prevention initiative.

with consistent approaches to evaluation and sharing learning.	**Gaps** • The audit plan contains no reference to evaluation and learning.
Whole-systems approach	
32. Collaborative working is embedded across professions, services, Health Boards and wider agencies involved in providing care and support, with a seamless transition between primary, secondary and tertiary care. This must include strong partnership working for regional services.	**Good and improving practice** • Individual quality improvement projects demonstrate cross-organisational working. • The safeguarding team in maternity described good cross-agency working. **Gaps** • Fragility of the clinical network for maternity and neonatal services. • Lack of connection between maternity and primary care services.
33. Integrated safeguarding systems and processes are in place with all partner organisations to ensure a holistic approach to keeping children and adults safe from violence, abuse and neglect.	**Good and improving practice** • This was evident from discussions with the safeguarding team in maternity.

Appendix 6 – Review team

Name	Role
Oversight panel	
Dr Denise Chaffer, CBE, FRGN	Chair of the Oversight Panel
Sarah Land, Co-Founder and Charity Manager of PEEPS HIE	Family Engagement Assurance
Dr Tony Kelly	Consultant Obstetrician and Gynaecologist
Dr Edile Murdoch	Consultant Neonatologist
Ken Sutton	Family Engagement Assurance
Clinical Reviewers	
Professor Alan Cameron	Clinical Reviewer, Consultant Obstetrician
Kelly Harvey	Clinical Reviewer, Advanced Neonatal Nurse Practitioner
Christine Bell	Clinical Reviewer, Midwife
Dr Alan Fenton	Clinical Reviewer, Consultant Neonatologist
Dawn Johnston	Clinical Reviewer, Midwife
Dr Heather Brown	Clinical Reviewer, Obstetrics and Gynaecology
Dr Deborah Horner	Clinical Reviewer, ITU and Anaesthetics
Family Engagement and Self-referral	
Chantal Knight, RGN, RM	Triage Midwife Self Referrals
Fiona Frizzell, Engagement Consultant	Family and public engagement
Cath Broderick, FRCOG (Hon Causa), MSc, BA (Hons), Engagement Consultant	Family and public engagement
Ann Ridley, Engagement Consultant	Family and public engagement
Governance, analytics and secretariat	
Sophie Stephenson, ICSA, ACA	Governance Specialist and Programme Lead
Michelle Carberry, ACA	Programme Lead
Dr Paul Smith, Director of Analytics	Analytics Programme Lead
Ashley Nuttall, Consultant	Workstream Consultant
Kate Jury, Managing Partner, Niche	Review Secretariat
James Fitton, Partner, Niche	Professional Standards Review, Review Equar
Mary-Ann Bruce	Scheduling and Programme Control

Appendix 7 – Extended data pack

This document provides a summary of the main datasets received from Swansea Bay University Health Board as part of the review of maternity services, along with a small number of external data sources, and covers the following:

- Episode level deliveries, births and neonatal data.
- Beds, capacity and ward stay data for maternity and neonatal wards.
- Maternity theatres data.
- Maternity quality metrics.
- Birthrate+ data.
- Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK) reports.
- The 2021 population census, and Welsh Index of Multiple Deprivation (WIMD) 2019 report.
- Statistics from the Welsh government maternity indicators data set. (https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/Maternity)

The analysis relating to births and deliveries is based on an initial extract of episodic data supplied by SBUHB which employed a slightly different methodology to that of the nationally-reported returns and understates births and deliveries by around 1 to 2%. The official numbers of births and deliveries per year as reported nationally by SBUHB are shown in the main report.

A. Population characteristics and maternity risk factors

This section provides analysis of the local population characteristics of Swansea, and key statistics from the maternity indicators data set from StatsWales for Swansea Bay University Health Board.

1. Overview

The following statements are taken from the 2021 England and Wales population census, and the Welsh Index of Multiple Deprivation (WIMD) 2019 report:

- For women aged between 16 and 49, based on the 2021 census, the population is mainly white (**88.6%**), with non-white groups representing the remaining 11.4% of the population. The largest non-white broad ethnic group was Asian, Asian British, or Asian Welsh, representing **6.3%** of the population.
- The Welsh Index of Multiple Deprivation (WIMD) 2019 identified **11.5%** of Swansea's local areas as falling within the top 10% most deprived in Wales, with **23.6%** falling within the top 20% most deprived, meaning, overall, Swansea had slightly above average proportions of its LSOAs featuring in the most deprived 10% and 20% of areas in Wales.
- There are 26 small areas of “deep-rooted deprivation”, considered the most deprived areas in Wales, spread across ten Local Authorities areas, with the highest number of these found in Swansea. These eight areas located in Swansea account for almost a third (31%) of those consistently ranking within the top 50 most deprived, twice as many as the Local Authorities with the next highest number.

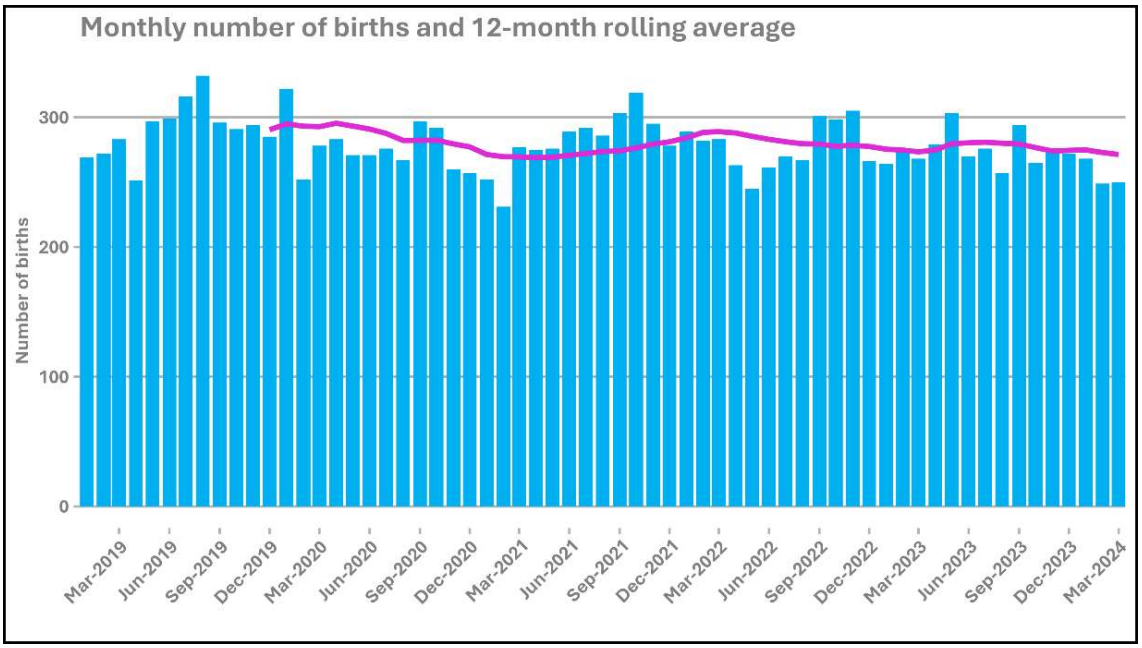
According to the StatsWales Maternity Indicators data set for 2023 (the latest year of data):

- SBUHB had **40.2%** of women reporting a mental health condition at initial assessment, compared to 31.6% for Wales (the highest reported percentage for all Health Boards).
- SBUHB had **74%** of women having an initial assessment carried out by 10 completed weeks of pregnancy, compared to 76.6% for Wales, and 60% for England (the England figure is for the year 2023/24)
- Public Health information showed that SBUHB had **31.5%** of women reporting a body mass index (BMI) of 30 or higher at initial assessment, compared to 31.9% for Wales. A person with a BMI of 30 or greater is considered obese, and the equivalent figure for England in 2023/4 was 26.2% (https://fingertips.phe.org.uk/search/overweight)
- SBUHB had **11.4%** of women having a recorded smoking status of smoking at initial assessment, compared to 13.8% for Wales, and 9.6% for England (based on 2022-23 MSDS data)
- SBUHB had **47.4%** of women having a mode of onset of labour recorded as spontaneous, compared to 45.1% for Wales, and 41.3% for England (based on 2022-23 MSDS data). The data from the Hywel Dda and Aneurin Bevan Health Boards was excluded for this indicator and therefore included five Health Boards only).
- SBUHB had **23.8%** of women having a mode of onset of labour recorded as caesarean section, compared to 19.8% for Wales (the highest reported percentage for all Health Boards) and 23.8% for England based on 2022-23 MSDS data. The data is again for five Health Boards.
- SBUHB had **28.8%** of women having a mode of onset of labour recorded as induction, compared to 35.2% for Wales (the lowest reported percentage for all Health Boards), and 29.3% for England (based on 2022-23 MSDS data). The data is for five Health Boards.
- SBUHB had **16.4%** of women having an epidural administered compared to 25.7% for Wales (the second lowest reported percentage for all Health Boards), and 26.0% in England in 2023
- SBUHB has consistently been highlighted in MBRRACE-UK reports as having higher proportions of mothers under 25 than the UK as a whole (21.3% for SBUHB vs 16.9% for the UK in 2018; 22.4% vs 16.4% in 2019; 20.9% vs 15.7% in 2020; 19.1% vs 14.5% in 2021; 18.1% vs 14.5% in 2022; and 17.3% for SBUHB vs 14.0% for the UK in 2023). In the national MBRRACE-UK Perinatal Mortality Surveillance Reports it can be seen that mortality rates were higher for babies born to mothers under 25 and over 34 years of age compared to mothers aged from 25 to 34 years old
- With the exception of the 2023 report, SBUHB has consistently being highlighted in MBRRACE-UK reports (for 2018, 2019, 2020, 2021 and 2022) as having mothers who were considerably more likely to live in areas of high deprivation than those giving birth across the UK as a whole. The anomaly in 2023 is likely to be attributable to a change in the way socio-economic deprivation was measured, using the “Children in low-income families local measure” for births until 2022, and using the “Children in low income families: local area statistics” measure for births in 2023.
- The results from the 2021 census, examining birth characteristics in England and Wales, show that 12.8% of all live births in England were to mothers resident in the 10% most deprived areas of the country, with a similar pattern in Wales with 12.7% of all live births to mothers resident in the 10% most deprived parts of the country in 2021. The equivalent figure for SBUHB in 2021 was 16.6% of births being to mothers resident in the 10% most deprived areas of the country. Stillbirth rates

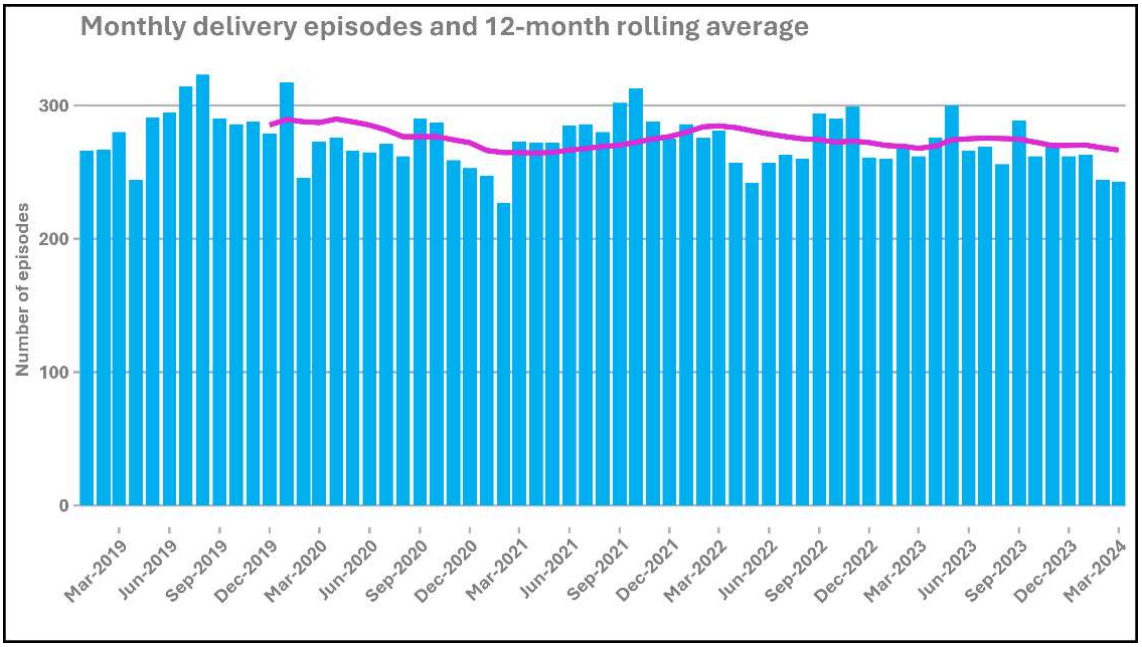
have consistently been higher for mothers resident in the most deprived areas with few fluctuations since 2015, as noted by the ONS.

2. Births and deliveries (January 2019 to March 2024)

There were **17,575** births recorded between January 2019 and March 2024, with an average of **279** births per month. This number is higher than the reported number of deliveries owing to multiple births for some deliveries, with **98.4%** of deliveries resulting in a single birth, **1.5%** resulting in two births, and the remainder resulting in three or more births).



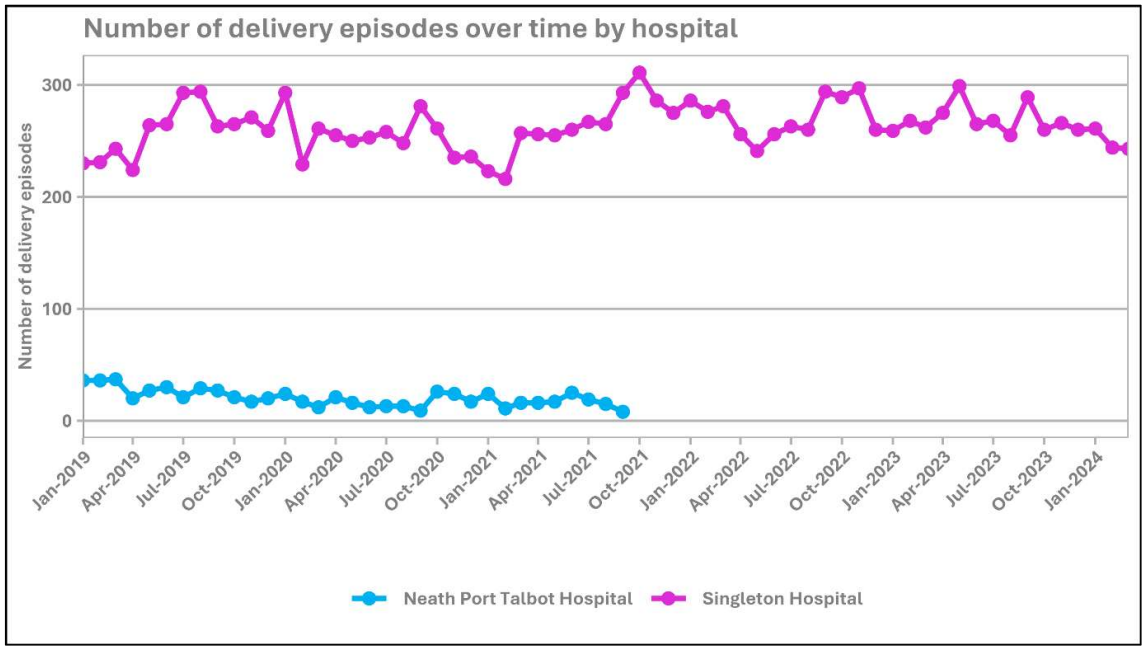
There were **17,264** deliveries recorded between January 2019 and March 2024, with an average of **274** per month. The 12-month rolling average number of deliveries fluctuated over the analysis period but decreased from an average of **285** deliveries per month in June 2019 to an average of **267** episodes per month in March 2024, a reduction of **6.5%** over 58 months.



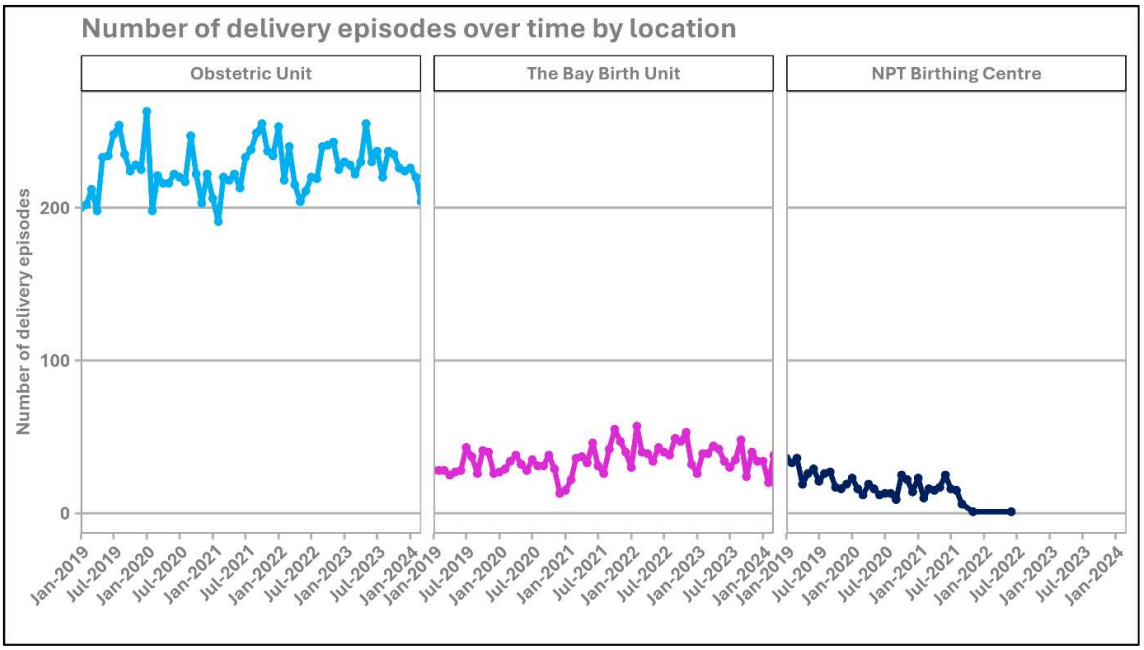
The table below shows the number of deliveries by year; 2024 only includes data for January, February and March. There were **183** fewer deliveries in 2023 compared to 2019, a reduction of **5.3%**.

Number of deliveries per year					
2019	**2020**	**2021**	**2022**	**2023**	**2024 (to March)**
3,423	3,265	3,320	3,266	3,240	750

The majority of deliveries over the period were recorded at Singleton Hospital, with **96%** of all deliveries recorded there; **4%** of deliveries were recorded at Neath Port Talbot Hospital, where the Birth Centre closed in September 2021.

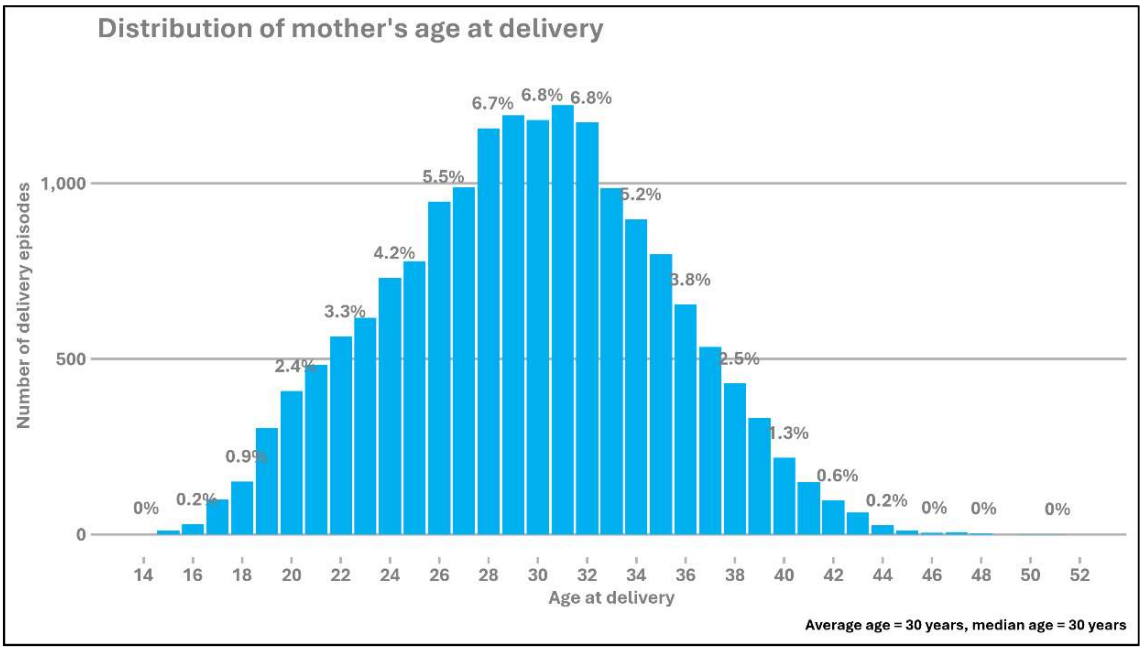


In total **82.4%** of all deliveries over the analysis period were recorded at the Obstetrics Unit, with **12.m7%** of deliveries recorded at the Singleton Midwifery Led Unit, and **3.7%** of deliveries at the Birthing Centre at Neath Port Talbot. There were also smaller volumes of deliveries recorded as home births, **0.8%** of deliveries over the period, and **0.3%** of births were recorded as other locations (for example born in transit or at another hospital).

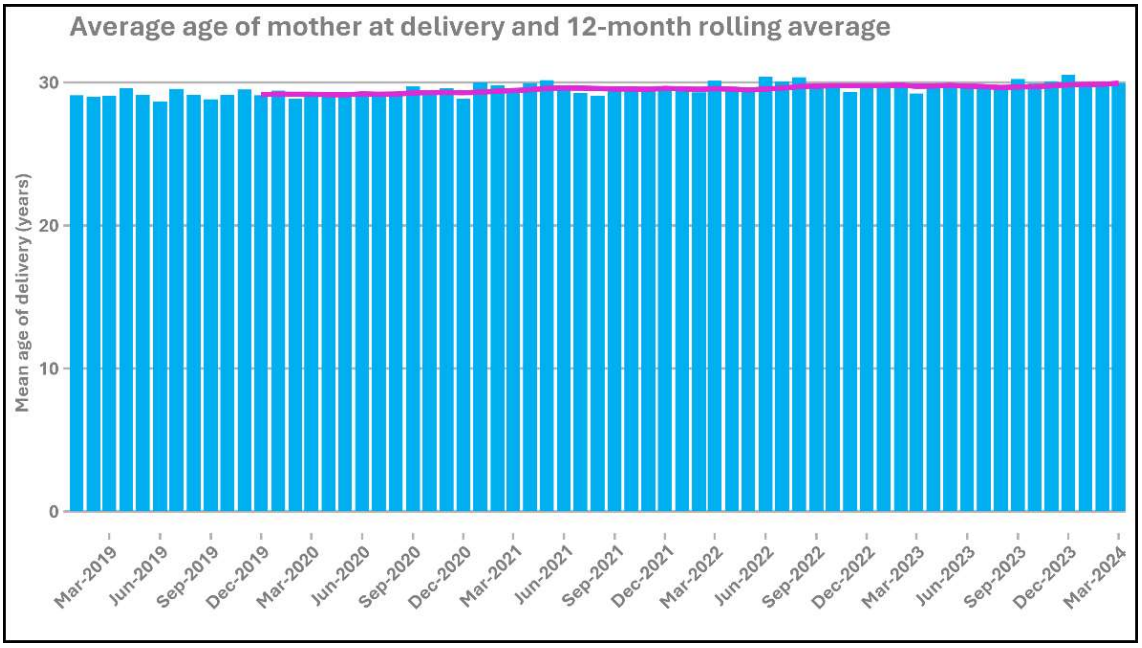


3. Mother's age at delivery (January 2019 to March 2024)

6% of mothers over the analysis period were 20 years of age or under at the time of the delivery, with 50% aged between 21 and 30, 42% aged between 31 and 40, and 2% of mothers were 40 years of age or over at the time of delivery. The mean age of mothers at delivery was 30 years.

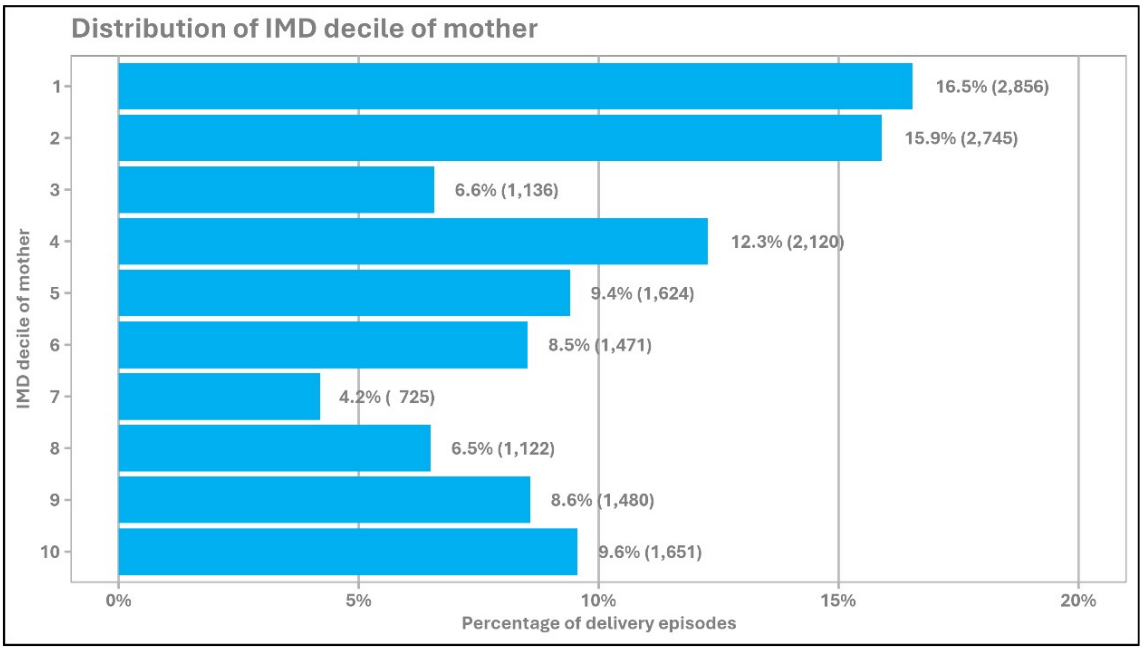


The average age of the mother at delivery was stable over the analysis period, rising slightly from a 12-month rolling average of **29.1** years in December 2019 to an average of **29.9** years in March 2024, an increase of **2.7%**.

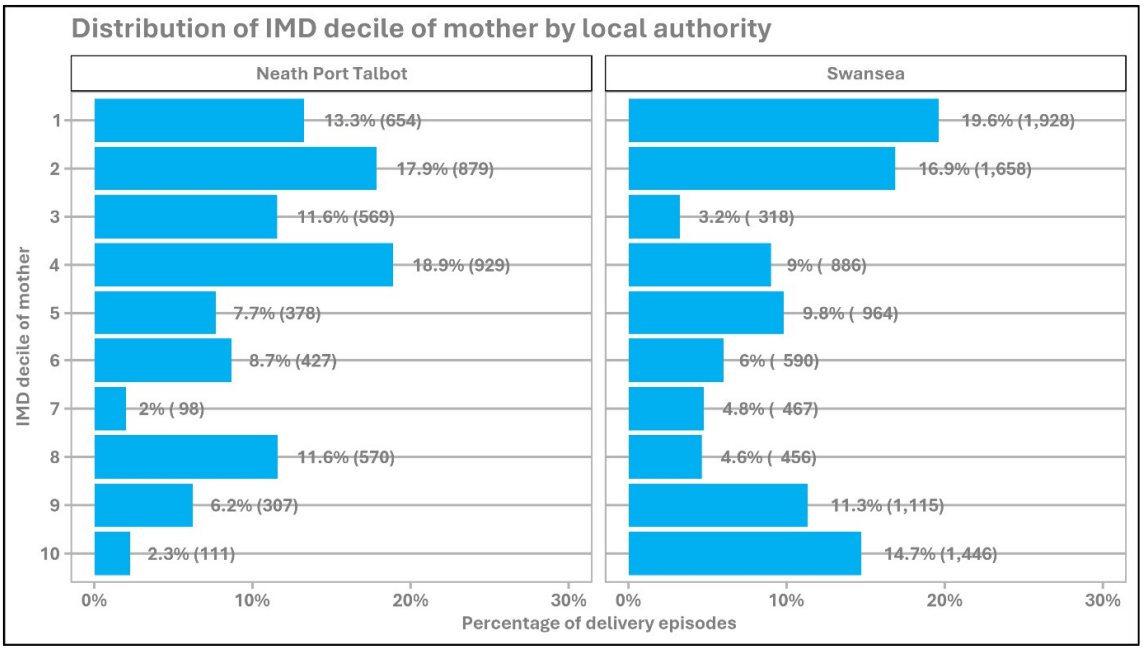


4. Deliveries and deprivation index (January 2019 to March 2024)

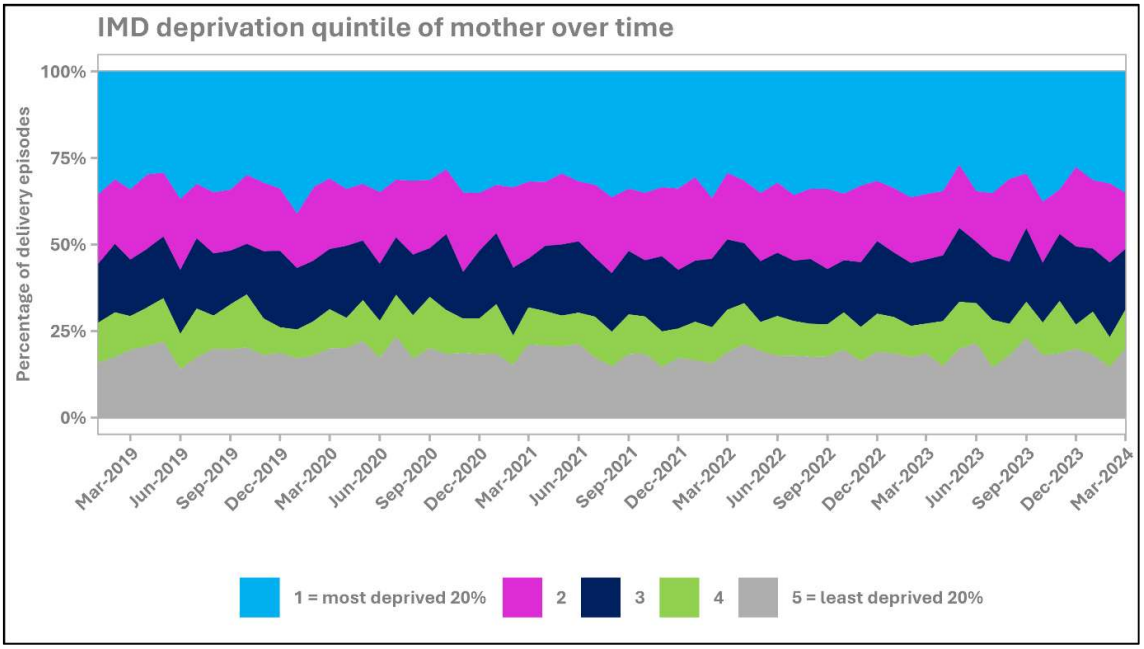
Nearly a third of all deliveries (**32.4%**) were for mothers living in the top 20% most deprived areas in Wales, with **51.3%** living in the top 40% most deprived areas. **18.1%** of all deliveries were for mothers living in the least deprived 20% of areas in Wales.



As shown below, nearly a third of all deliveries (**31.2%**) from Neath Port Talbot were for mothers living in the top 20% most deprived areas in Wales, compared to **36.5%** for Swansea, who also had a high proportion of deliveries, **19.6%**, from the top 10% most deprived areas in Wales. Swansea, however, was also more diverse in terms of deprivation profile, with **26.0%** of all deliveries were for mothers living in the least deprived 20% of areas in Wales.

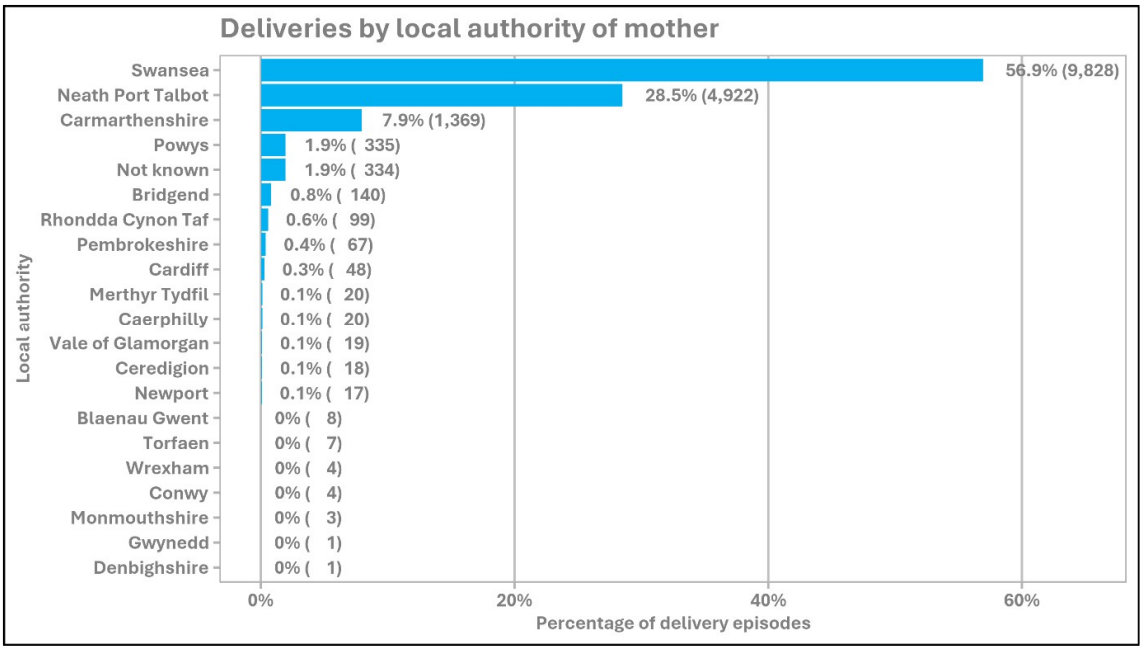


The distribution of the deprivation index for deliveries was stable between January 2019 and March 2024 (see below).



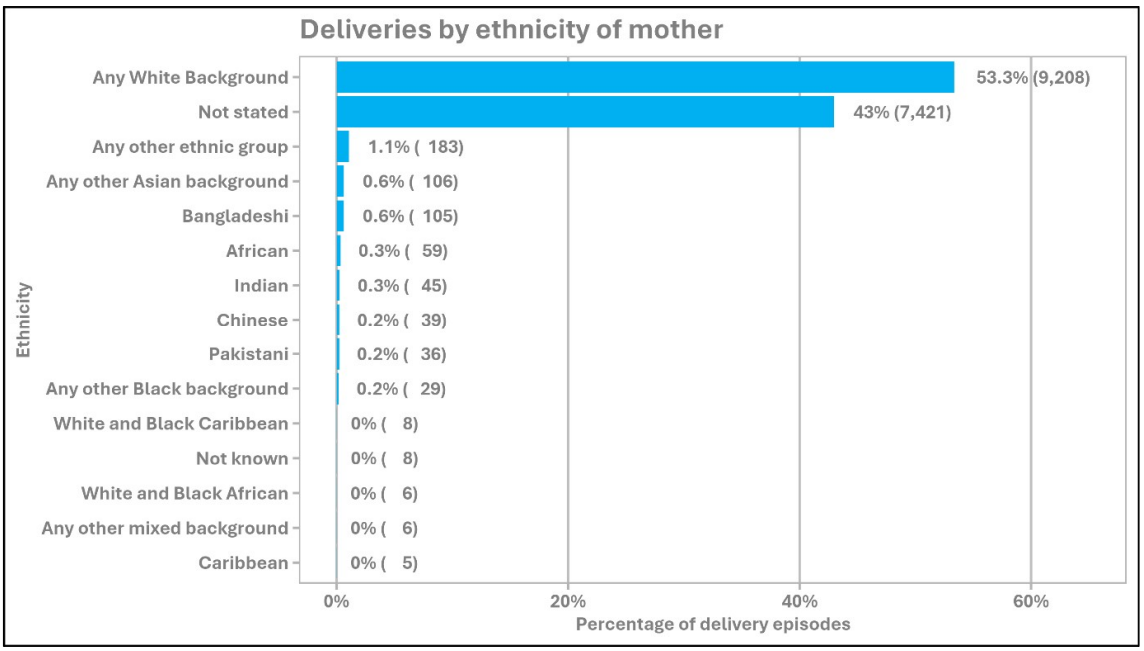
5. Deliveries and local authority of residence (January 2019 to March 2024)

The majority of deliveries, **56.9%**, were for mothers living in Swansea, with **28.5%** of deliveries for mothers who lived in Neath Port Talbot and **7.9%** for mothers living in Carmarthenshire. The remaining local authorities accounted for around **6.7%** of deliveries over the period.



6. Deliveries and ethnicity of mother (January 2019 to March 2024)

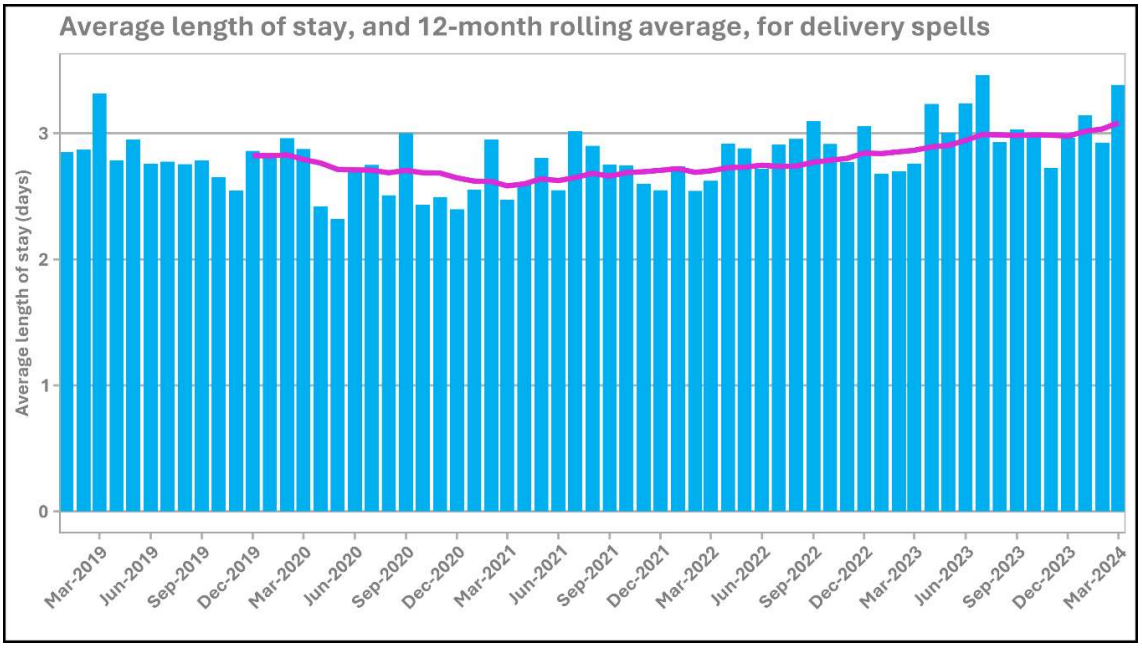
The majority of mothers (**53.3%**) giving birth over the data period had an ethnicity of "Any White Background," with **43%** of ethnicities recorded as "Not Stated".



B. Activity and performance

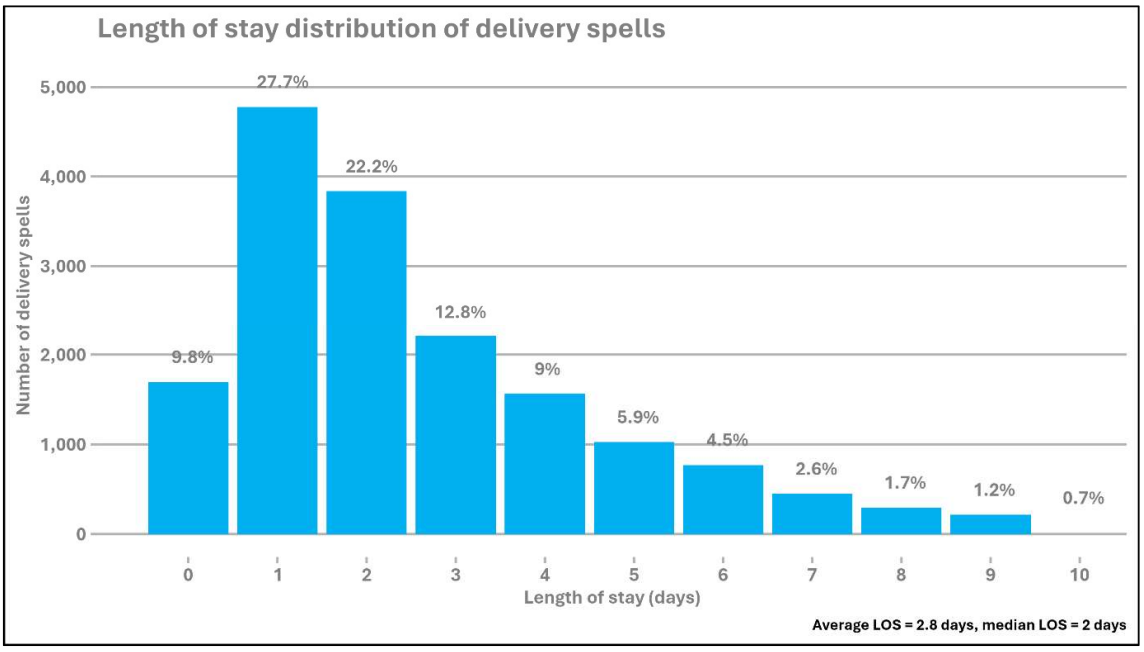
7. Average length of stay in hospital (January 2019 to March 2024)

The average length of stay in hospital for women who had given birth was 2.8 days between January 2019 and March 2024. The overall average length of stay was 2.8 days in 2019, increasing to 3 days in 2023 . The average length of stay has been increasing since early 2021, rising from an average of 2.6 days in March 2021 to 3.1 days in March 2024, an increase of 19%.



The chart below shows that:

- almost 60% of women stayed in hospital for two nights or less; this metric has remained static over the period from 2019 to 2023;
- 37.5% stayed one night or less (36% in 2019 and just over 37% in 2023);
- almost 10% of women were discharged on the same day (with no overnight stay); this has remained static over the period;
- over a quarter of women (28%) stayed in hospital for more than three nights and this has remained static over the period. The percentage of women staying in hospital for three nights or more (40%) has also remained static over the period.

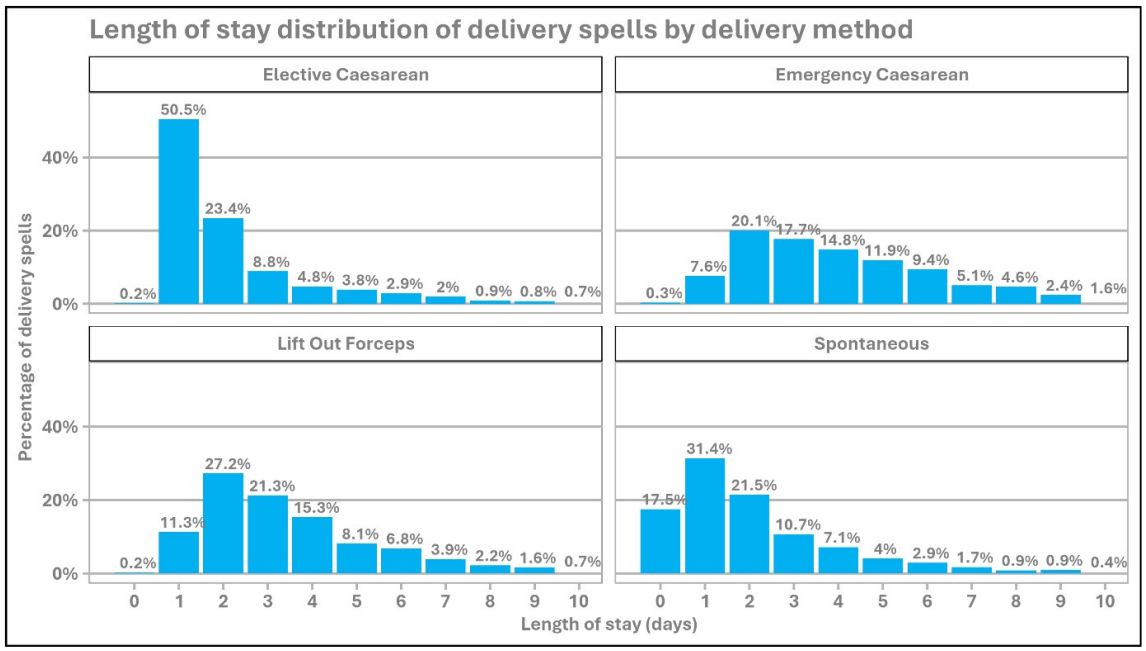


8. Average length of stay by mode of delivery (January 2019 to March 2024)

Examining mode of delivery and lengths of stay (see below):

- For spontaneous deliveries, the average length of stay was just over 2 days (2.2 days in 2019 and rising to 2.5 days in 2023, an increase of almost 23%).
- Following an emergency caesarean section, length of stay increased to 4-5 days (2-3 days for an elective caesarean section); this measure remained static over the period from 2019-2023.
- Average length of stay following an elective caesarean section in 2019 was 2.6 days, falling to 2.3 days for 2023 (a decrease of over 13%).
- For assisted deliveries (forceps/ventouse), average lengths of stay ranged from 3 to 3.5 days and this has been decreasing over the period from 2019 to 2023.

Delivery Method	Deliveries (Jan 2019 to Mar 2024)	Mean length of stay (days)	Median length of stay (days)
Spontaneous	9,544	2.2	2.0
Emergency Caesarean	3,397	4.6	4.0
Elective Caesarean	2,509	2.3	1.0
Lift Out Forceps	922	3.6	3.0
Other Forceps	236	3.6	3.0
Kiwi	210	2.9	2.0
Rotational Forceps	195	3.3	3.0
Ventouse	174	3.2	2.0
LSCS + Tubal Ligation	71	3.3	2.0
Assisted Breech	5	3.8	4.0
Breech Extraction	1	9.0	9.0



Across all delivery spells, and for each delivery type, as shown in the table below induction of labour increased the average length of hospital stay. For all spells, the average length of stay was **1.7** days longer for women who had an induction of labour, an increase of **70%**, and for spontaneous deliveries the average length of stay was **1.8** days longer for women who had an induction of labour, an increase of **112%**.

Delivery Method	Delivery spells (Jan 2019 to Mar 2024)	Average length of stay in days (no induction of labour)	Average length of stay (induction of labour)
Spontaneous	9,544	1.6	3.4
Emergency Caesarean	3,397	4.3	5.0
Lift Out Forceps	922	2.9	4.4
Other Forceps	236	2.8	4.6
Kiwi	210	2.3	3.9
Rotational Forceps	195	2.7	4.3
Ventouse	174	2.2	4.7
Other method	2,586	2.4	4.5
All deliveries	17,264	2.3	4.0

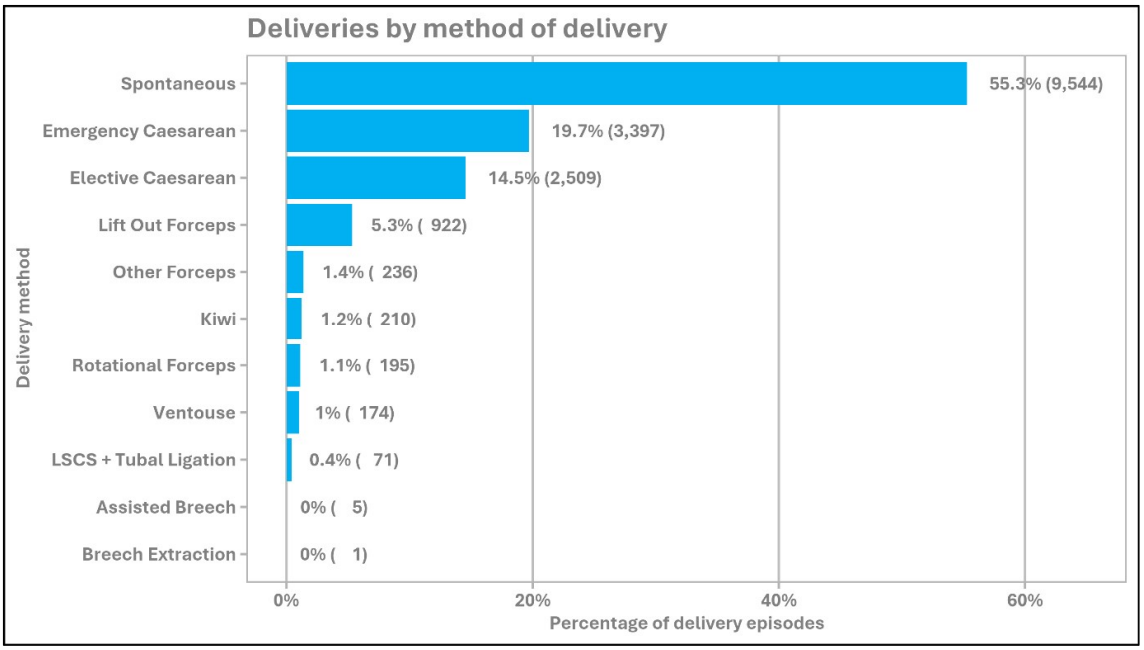
9. Length of stay and estimated parity (April 2023 to March 2024)

As the deliveries data only encompassed 63 months the definitions of parity shown in the table below are estimates only. Defining April 2023 to March 2024 as the index period, primiparous women were defined as women who gave birth between April 2023 and March 2024 with no births in the previous 51 months, and multiparous women as women who gave birth between April 2023 and March 2024 with one or more births in the previous 51 months. Across all deliveries, multiparous women had shorter lengths of hospital stay than primiparous women, although this varied by delivery method, and, for reasons outlined, these results should be treated with caution.

Delivery method	Deliveries (Apr 2023 to Mar 2024)	Average length of stay in days (primiparous women)	Average length of stay in days (multiparous women)
Spontaneous	1,688	2.8	2.1
Emergency Caesarean	694	4.9	5.0
Elective Caesarean	521	2.5	1.7
Other method	296	3.3	3.7
All deliveries	3,199	3.3	2.4

10. Method of delivery (January 2019 to March 2024)

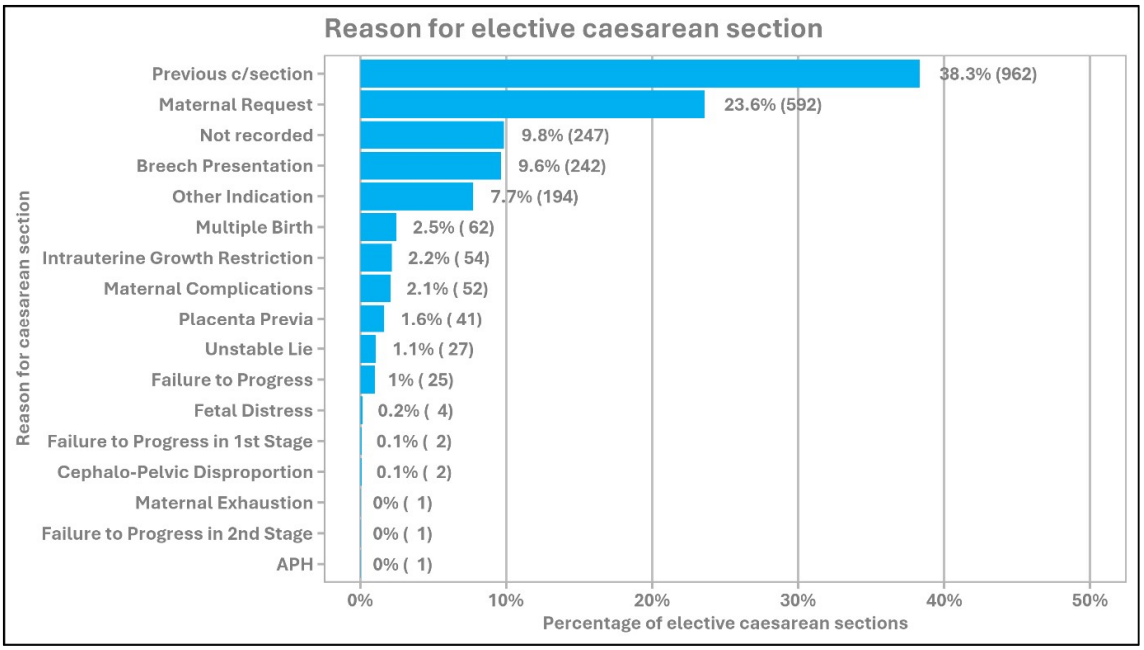
In total **55.3%** of all deliveries over the analysis period were spontaneous, with over a third (**34.2%**) of deliveries by Caesarean section (see chart below).



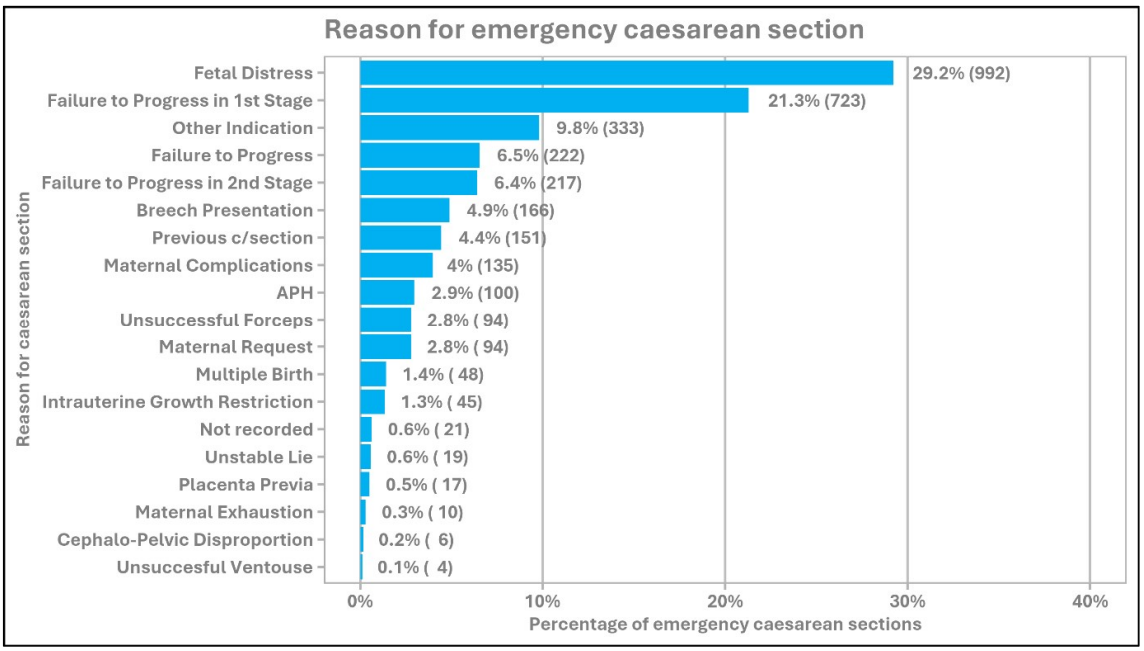
The proportion of deliveries taking place by caesarean section (both elective and emergency) increased between 2019 and 2023 from **29.2%** of all deliveries to **37.2%**, there was also reduction in the proportion of deliveries taking place by spontaneous vertex over this period from **59.9%** of all deliveries to **51.3%**.

	Percentage of deliveries					
Delivery Method	**2019**	**2020**	**2021**	**2022**	**2023**	**2024 (to March)**
Spontaneous	59.9%	56.3%	55.5%	51.7%	53.6%	51.3%
Emergency Caesarean	17.1%	17.0%	20.4%	22.2%	21.0%	23.1%
Elective Caesarean	12.1%	14.2%	14.2%	15.8%	16.2%	16.1%
Lift Out Forceps	5.5%	6.7%	4.8%	5.5%	4.5%	4.3%
Other Forceps	1.4%	1.5%	1.4%	1.6%	1.1%	0.8%
Kiwi	1.4%	1.1%	1.4%	1.2%	0.9%	1.3%
Rotational Forceps	1.2%	1.4%	0.9%	0.9%	1.2%	1.5%
Ventouse	0.9%	1.4%	1.1%	0.6%	1.0%	1.1%
LSCS + Tubal Ligation	0.4%	0.4%	0.3%	0.5%	0.5%	0.5%
Assisted Breech	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%
Breech Extraction	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

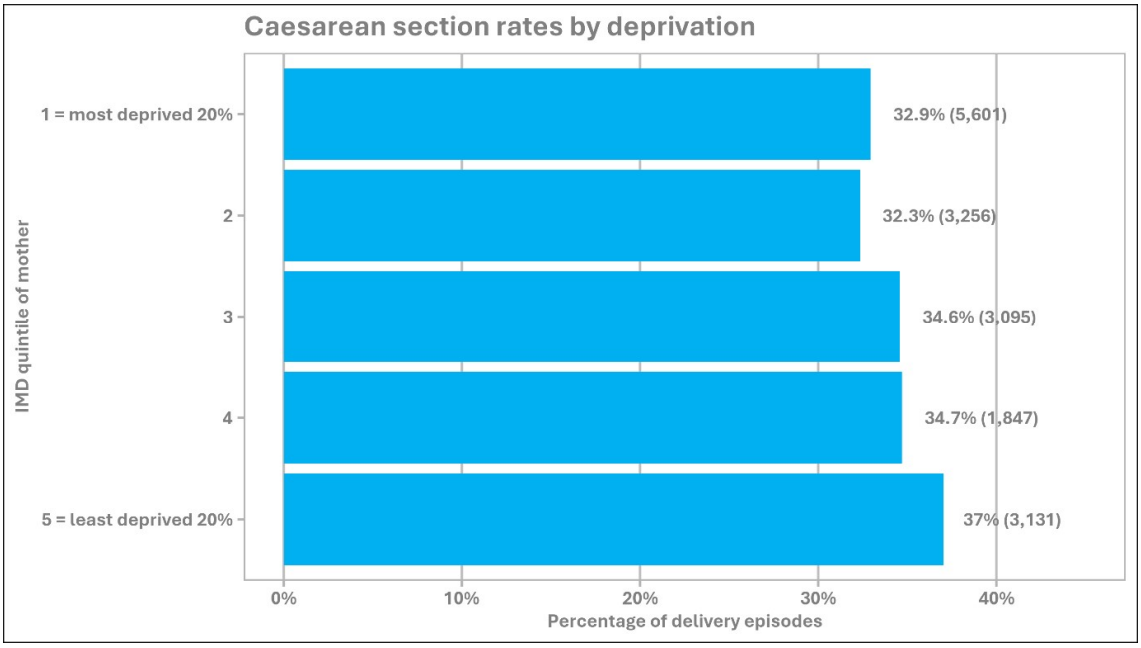
The most common reason for an **elective** caesarean section was due to a previous caesarean section, accounting for **38.3%** of elective caesarean sections between January 2019 and March 2024.



The most common reason for an **emergency** caesarean section was due to fetal distress, accounting for **29.2%** of emergency caesarean sections between January 2019 and March 2024.



As shown in the chart below, mothers from less deprived areas were more likely to have a caesarean section, with **37.0%** of deliveries from mothers in the 20% least deprived areas in Wales delivering via caesarean section, compared to **32.9%** for mothers in the 20% most deprived areas.

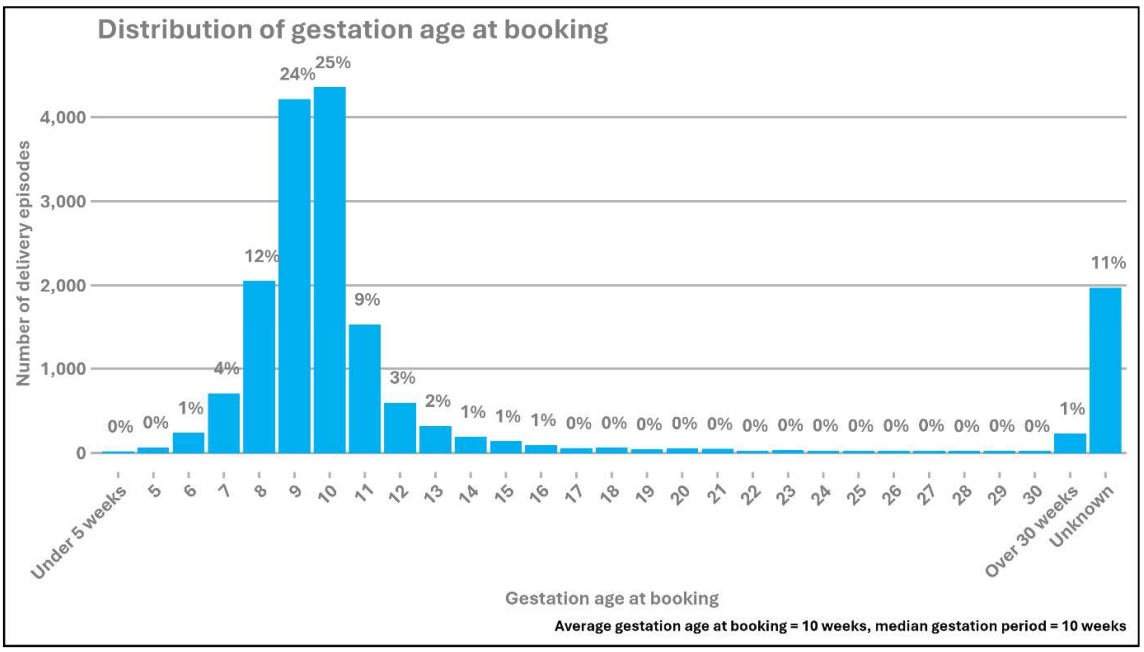


11. Gestational age at booking (January 2019 to March 2024)

Maternity data for Wales (StatsWales) showed that for SBUHB in 2023, 74% of women had an initial assessment carried out by ten completed weeks of pregnancy which is similar to Wales overall (77%). SBUHB data shows that over the period from January 2019 to March 2024:

- 61% of bookings were undertaken at a gestational age of between 9-12 weeks;
- almost 9% of bookings were after 12 weeks (1,498); and
- in 11% of cases, gestational age at booking was not recorded.

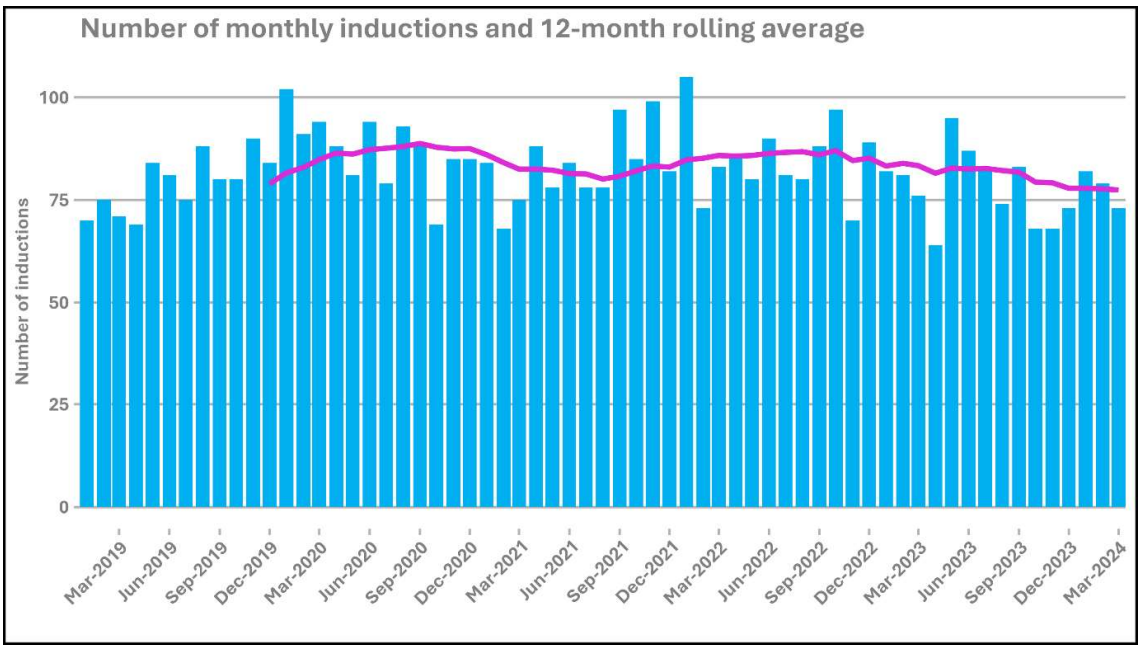
The mean and the median gestational age at booking was 10 weeks.



12. Inductions of labour (January 2019 to March 2024)

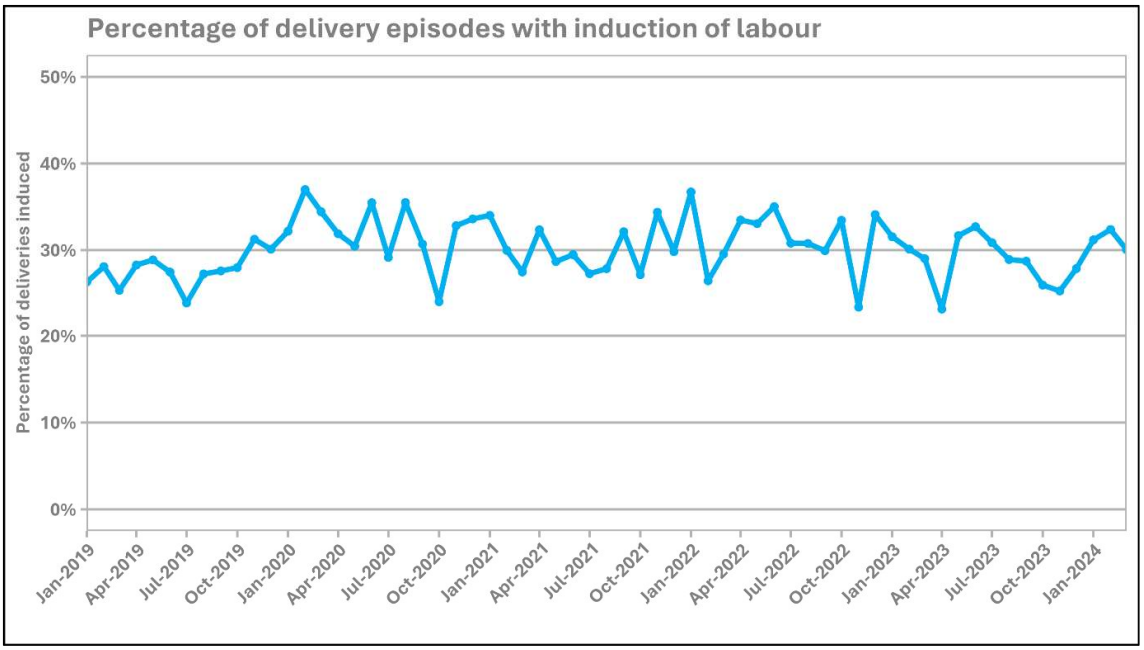
National data for 2023 (StatWales) showed that for SBUHB, almost 29% of women had an induction of labour, compared to over 35% for Wales; this was the lowest reported percentage for all Health Boards in Wales. For England, the comparator was just over 29% (MSDS 2022/23).

There were an average of **82** inductions per month between January 2019 and March 2024 and, whilst monthly volumes fluctuated, the 12-month rolling average number of inductions at the start of the period (**79** in December 2019) was similar to the rolling average at the end of the period (**77** by March 2024).



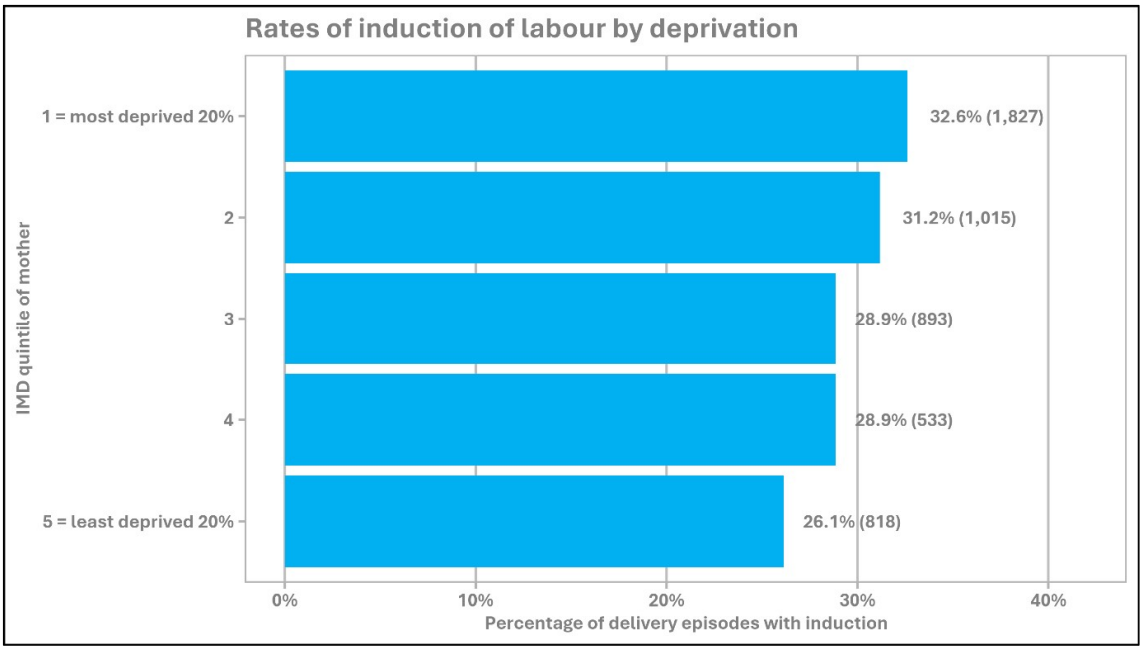
Labour was induced for 30% of deliveries overall between January 2019 and March 2024. The rate of induction as a proportion of total deliveries was variable but ranged from almost 28% in 2019 to 31-32%.

Year	Number of deliveries	Number of inductions	% of inductions
2019	3,423	947	27.7%
2020	3,265	1,050	32.2%
2021	3,320	996	30.0%
2022	3,266	1,022	31.3%
2023	3,240	934	28.8%
2024 (to March)	750	234	31.2%



13. Inductions of labour and deprivation banding (January 2019 to March 2024)

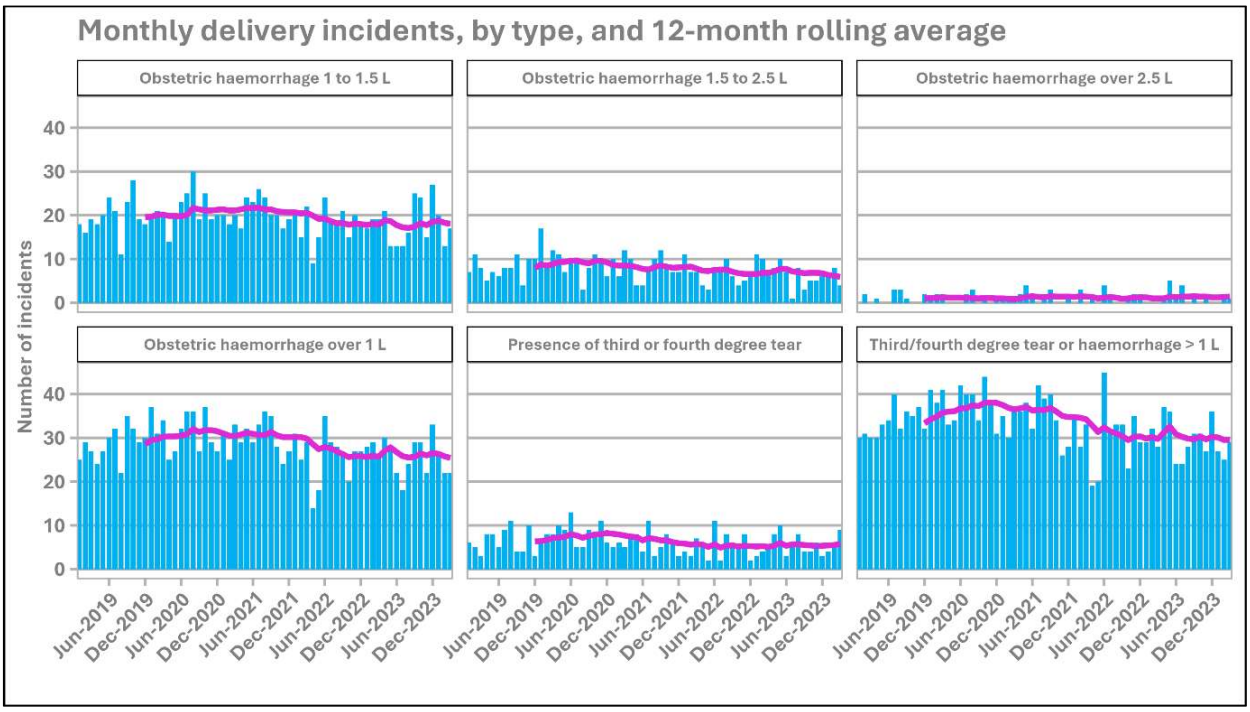
Mothers from more deprived areas were more likely to have labour induced, with **32.6%** of deliveries following induction from mothers in the 20% most deprived areas in Wales, compared to **26.1%** of deliveries from mothers in the least deprived 20% of areas.



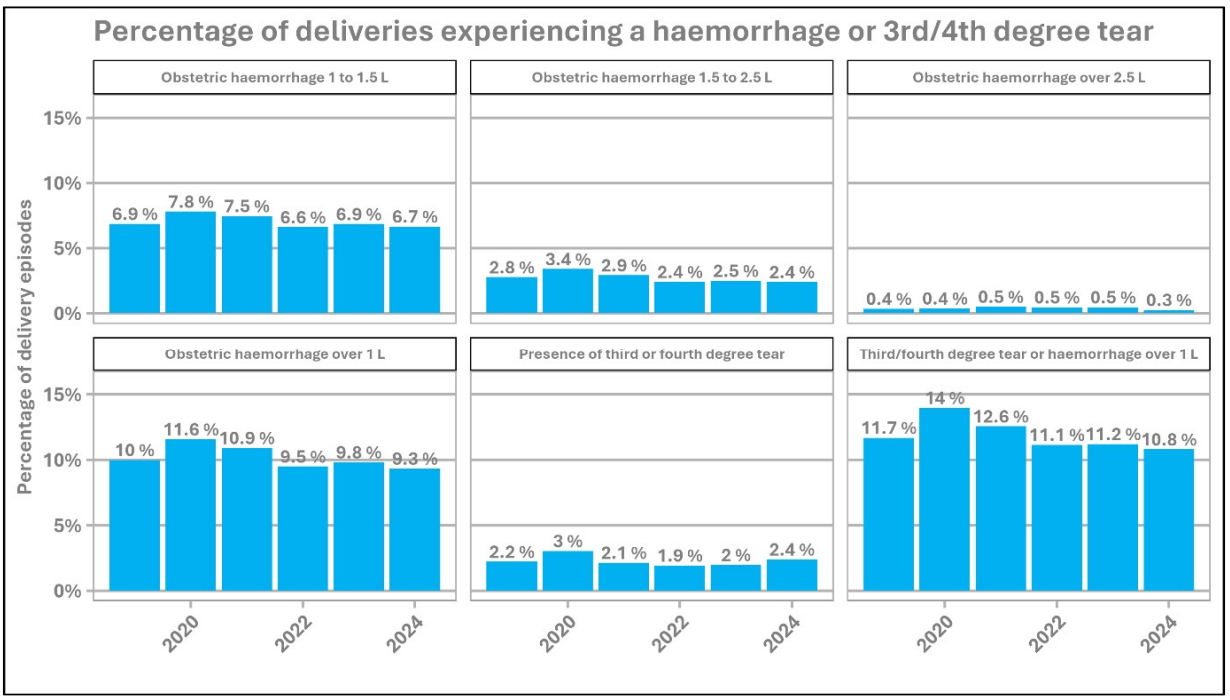
14. Obstetric haemorrhage and perineal tears (January 2019 to March 2024)

The following charts show the rates of obstetric haemorrhage and third/fourth degree vaginal tear per 1,000 deliveries over the period from 2019 to 2024. A major obstetric haemorrhage is defined in Welsh guidelines as a loss of over 1.5 litres.

There has been an overall reduction in the rate of both obstetric haemorrhages and third or fourth degree tears.



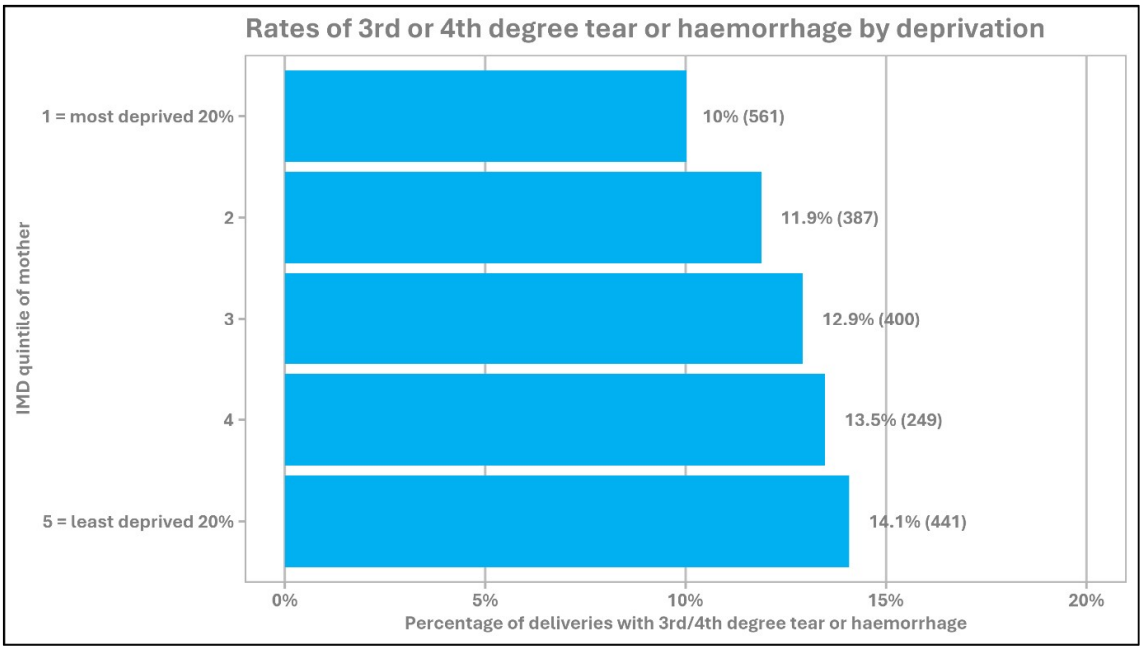
The proportion of deliveries recorded with an obstetric haemorrhage, or third or fourth degree tear, exhibited a spike in 2020, with **14.0%** of all deliveries recorded with one or more of these incidents.



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

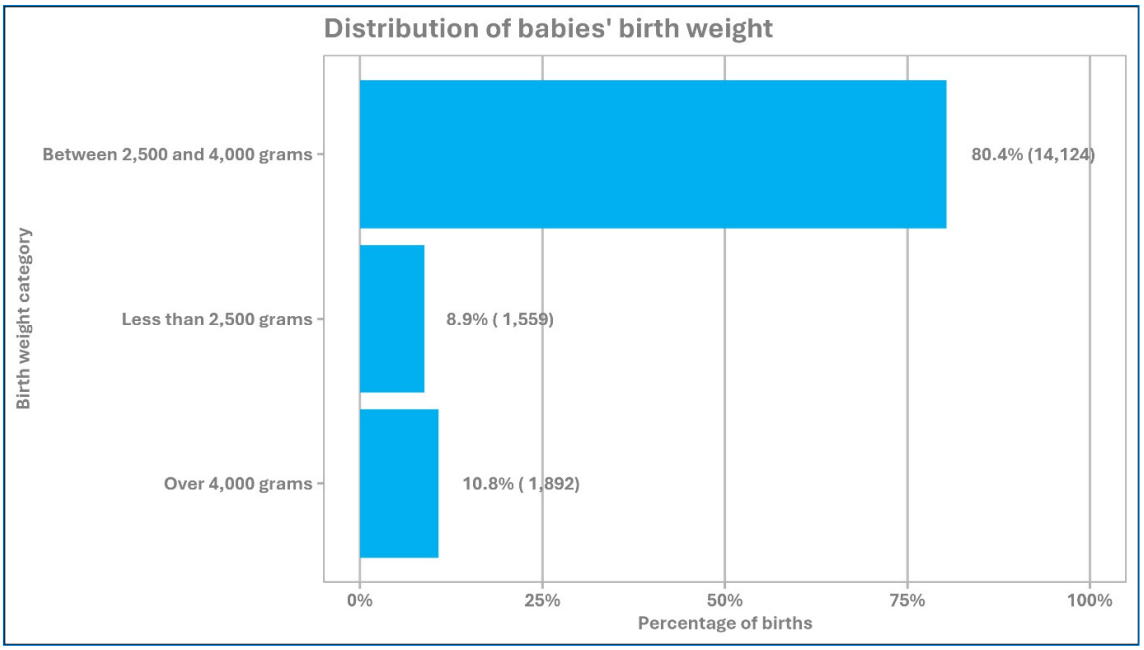
15. Obstetric haemorrhage or tear by deprivation quintile

Mothers from less deprived areas were more likely to have an obstetric haemorrhage or third or fourth degree tear recorded, with **14.1%** of deliveries from mothers in the 20% least deprived areas having one of these incidents recorded, compared to **10.0%** of deliveries from mothers in the most deprived 20% of areas.

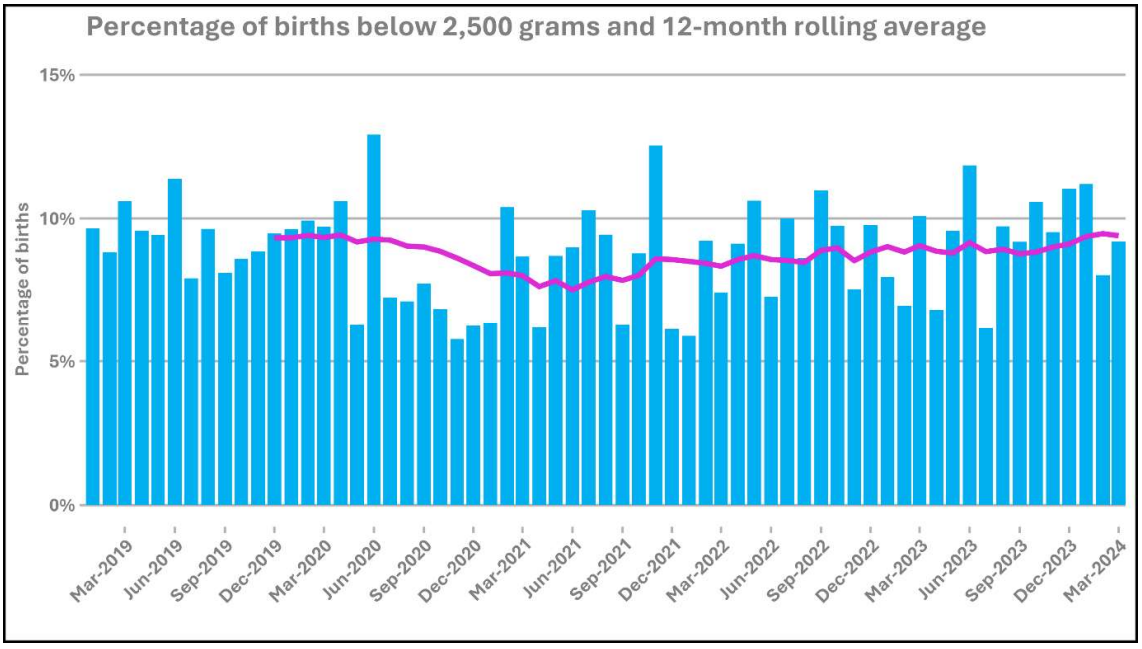


16. Babies' birth weight (January 2019 to March 2024)

The average birth weight recorded between January 2019 and March 2024 was **3,313** grams, with a median birth weight of **3,385** grams. In total **80.4%** of all births over the period were between 2,500 and 4,000 grams, with **8.9%** of birth weight less than 2,500 grams.

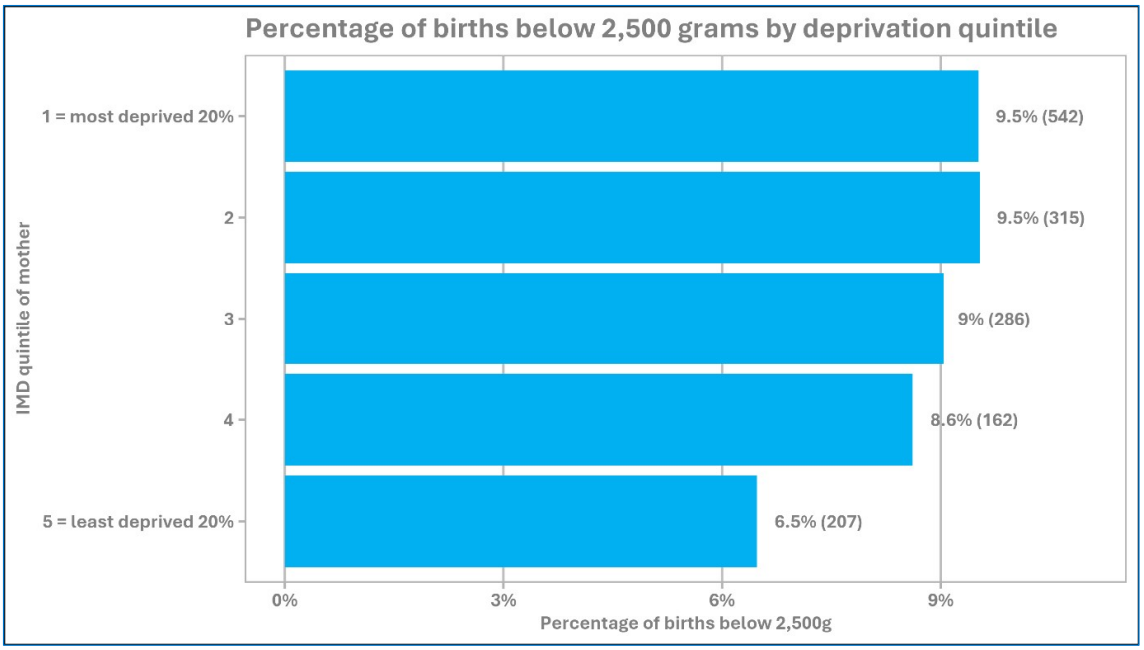


The following chart shows the percentage of births with a birth weight below 2,500 grams. The 12-month rolling average percentage of births below 2,500g decreased sharply between April 2020 and June 2021, from 9.3% of births to 7.5% of births. From June 2021 onwards, however, there has been steady increase in this proportion, with a rolling average of 9.4% of births with a birth weight below 2,500g in March 2024.



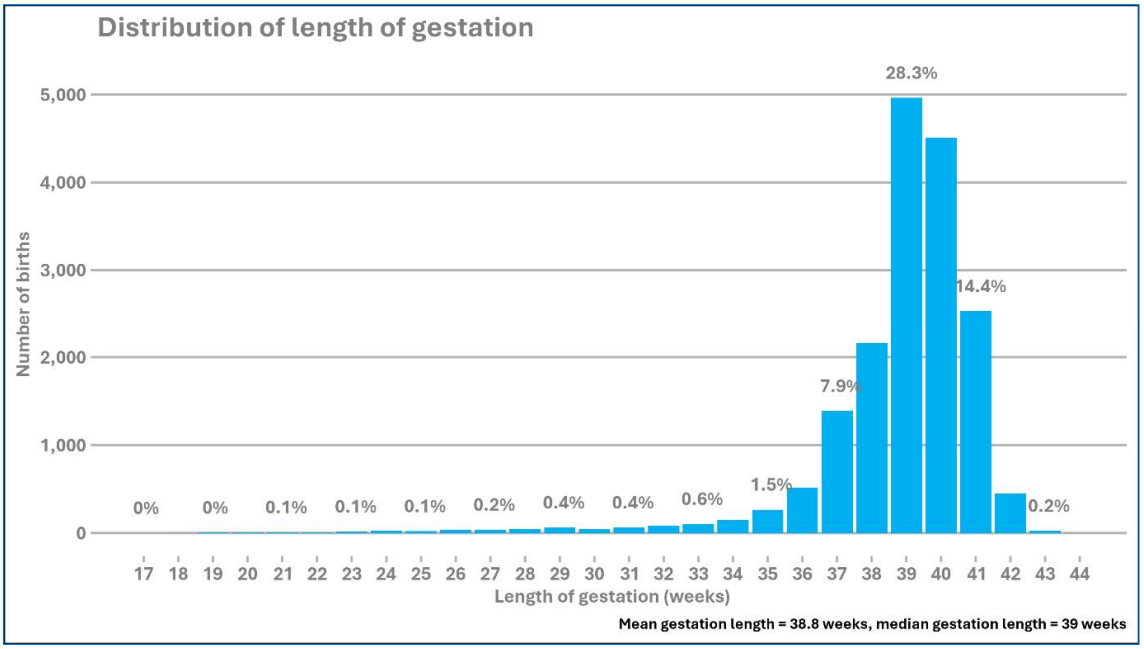
17. Birth weight and deprivation (January 2019 to March 2024)

Mothers from more deprived areas were more likely to have a baby with a birth weight under 2,500g, with **9.5%** of births from mothers in the 20% most deprived areas having a birth in this weight category, compared to **6.5%** of births from mothers in the least deprived 20% of areas.



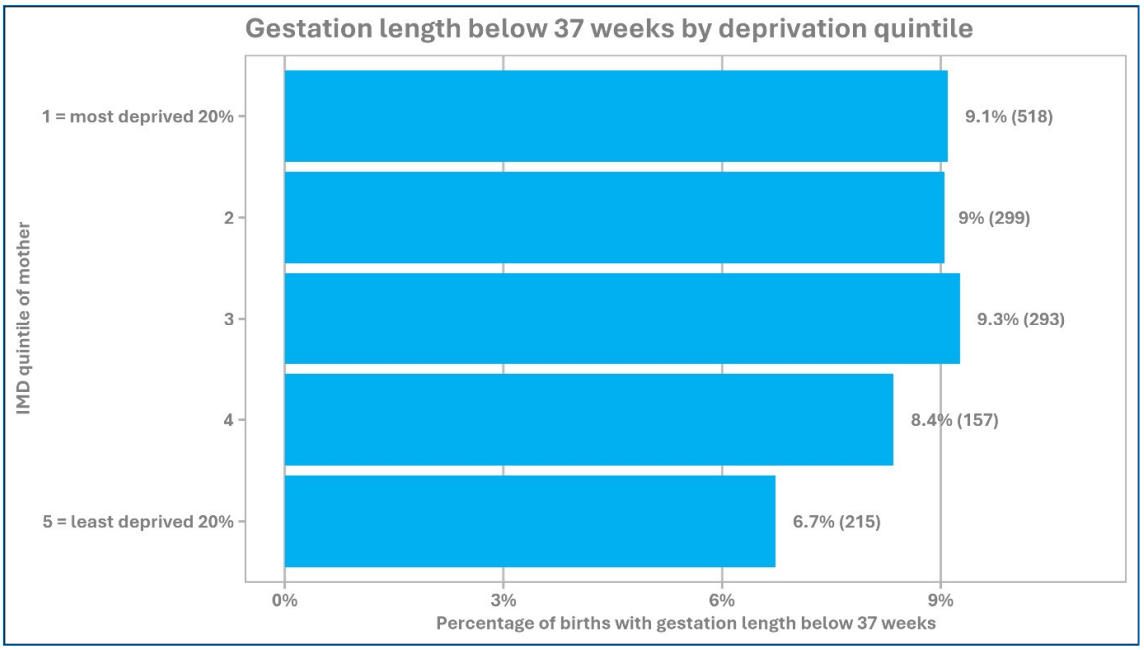
18. Gestational age (January 2019 to March 2024)

Gestation lengths ranged from a minimum of 17 weeks to a maximum of 44 weeks between January 2019 and March 2024, with a mean gestation length of **38.8** weeks and a median gestation length of **39** weeks. In total **8.7%** of births had a gestation length of less than 37 weeks, **91.2%** had a gestation length between 37 and 42 weeks, and **0.3%** had a gestation length of over 42 weeks.



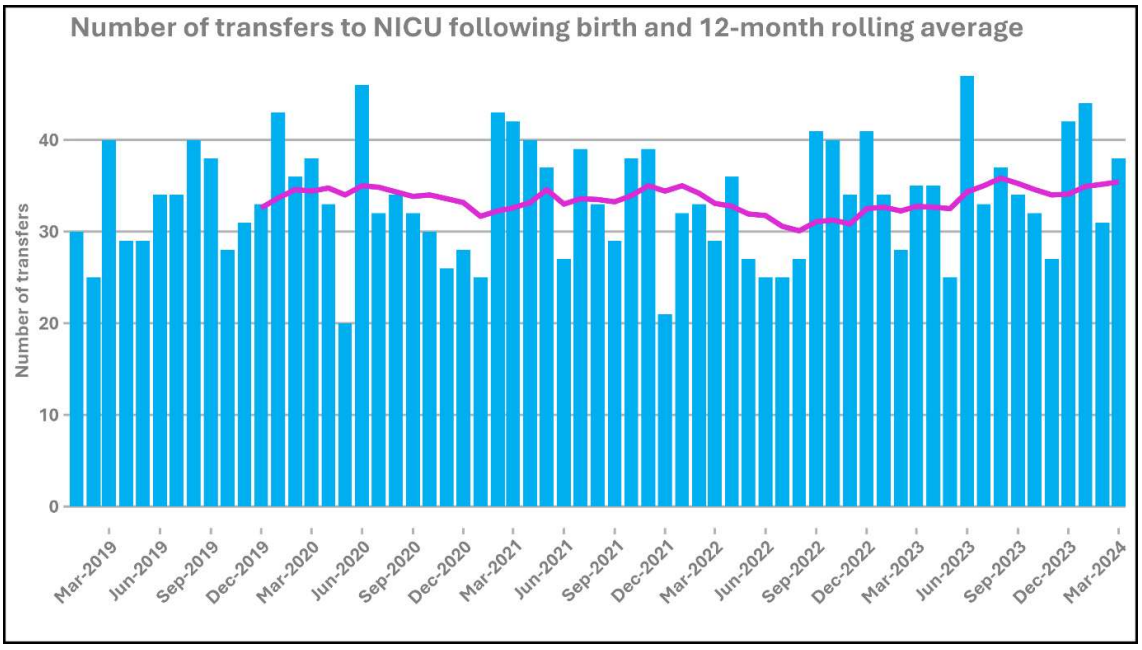
19. Gestational age and deprivation (January 2019 to March 2024)

As shown below, mothers from less deprived areas were less likely to have a birth with a length of gestation under 37 weeks, with **6.7%** of births from mothers in the 20% least deprived areas having a birth in this category, compared to an overall average of **8.7%**.

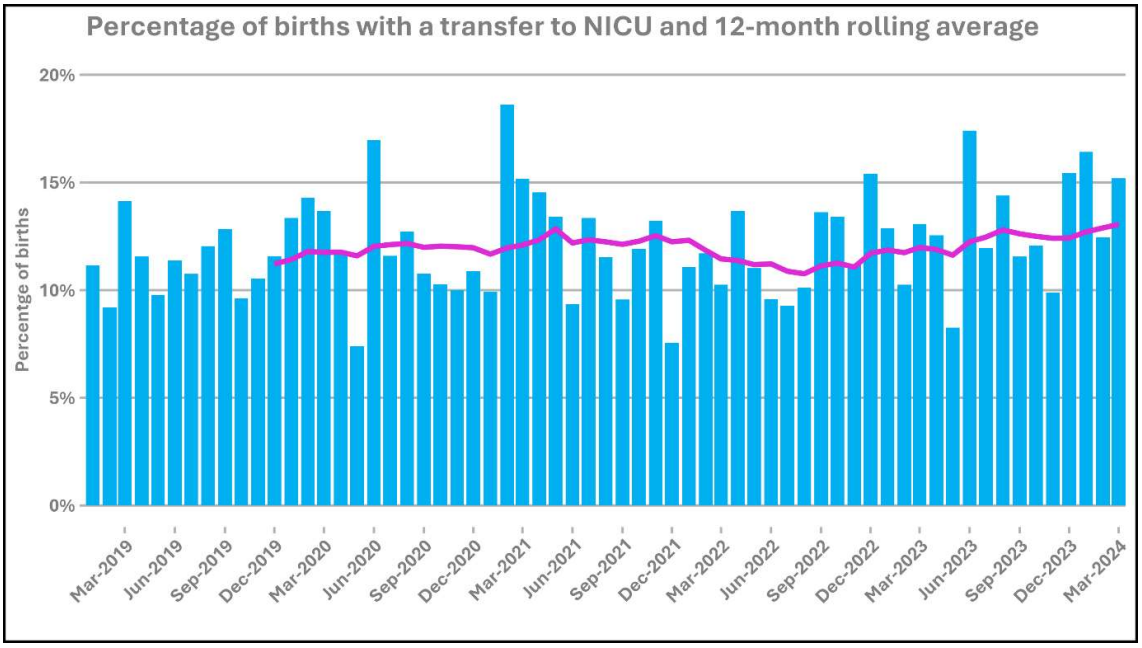


20. Transfers to NICU (January 2019 to March 2024))

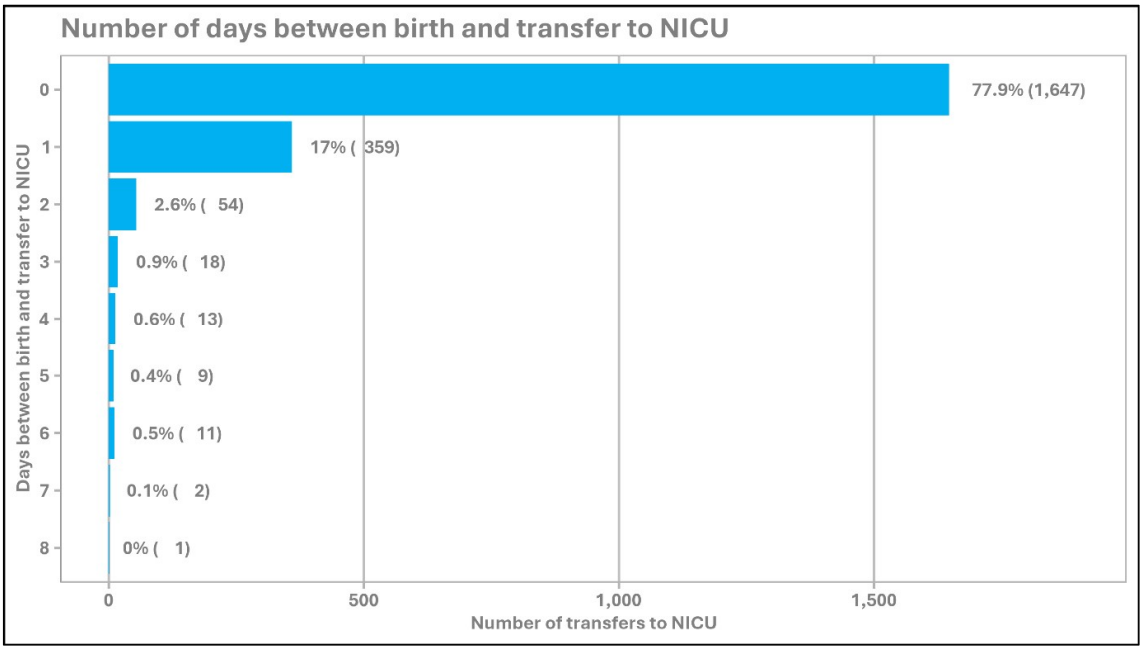
In total **2,114** babies were transferred to NICU following birth between January 2019 and March 2024, with an average of **33.6** transfers per month.



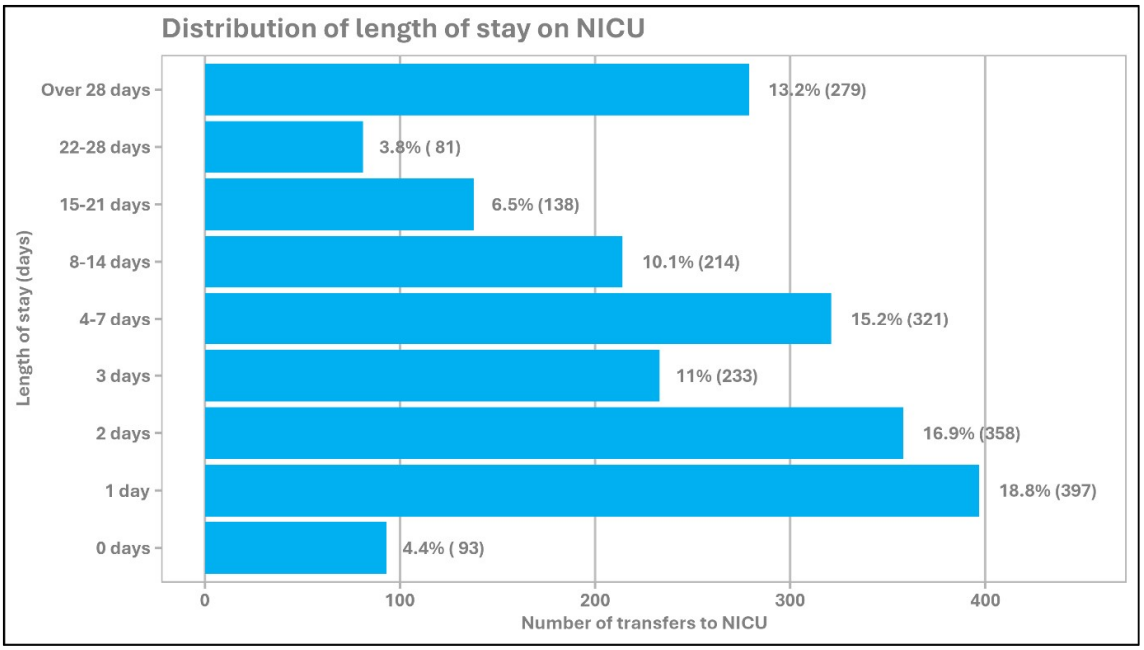
As shown below, between January 2019 and March 2024 **12%** of babies were transferred to NICU following birth. The 12-month rolling average was relatively stable over the analysis period, ranging between **10.8%** and **13.1%**. There was larger variation between individual months, ranging from **7.4%** to **18.6%** of new births transferring to NICU.



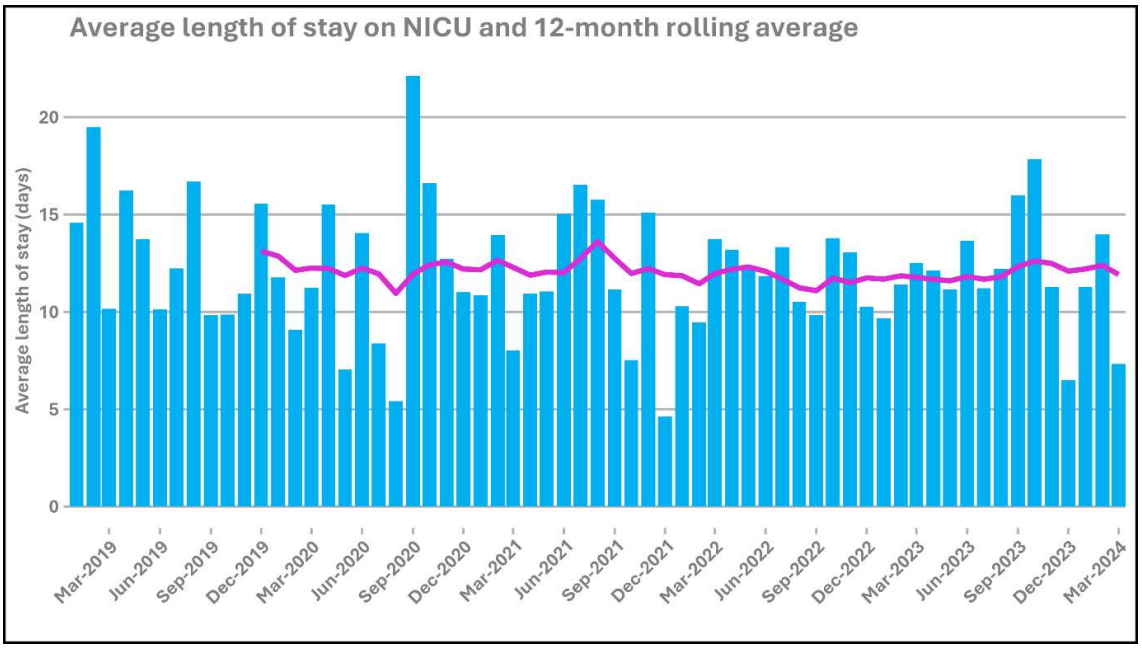
The majority of babies requiring transfer to NICU, **77.9%**, were transferred on the same day, with **94.9%** transferred either on the same day or the next day.



As shown below, most babies requiring a transfer to NICU stayed there for three days or less, **51.1%,** with nearly two-thirds (**66.3%**) staying a week or less. A sizeable minority of babies, **13.2%,** stay on NICU for more than a month.



The overall average length of stay for babies transferred to NICU between January 2019 and March 2024 was **12.1** days. The 12-month rolling average was relatively stable over the analysis period, ranging between **10.9** days and **13.6** days.

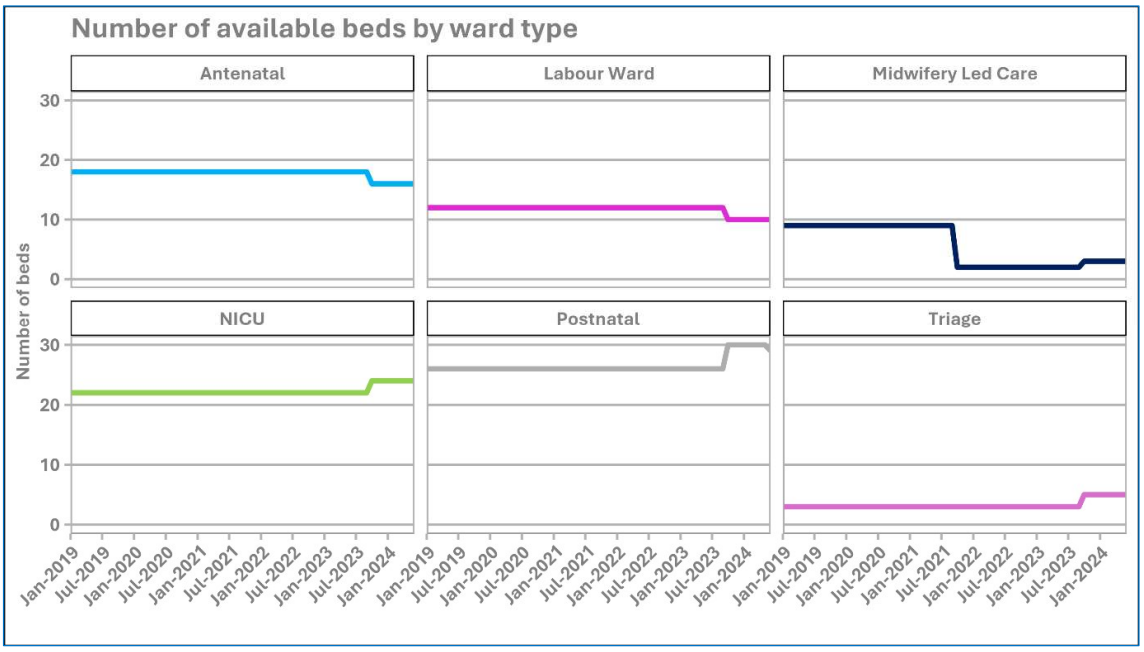


D. Bed capacity and occupancy

21. Number of allocated beds on maternity or neonatal wards (January 2019 to June 2024)

The chart below shows the number of available beds, by ward type and month, for maternity and neonatal wards at Singleton Hospital and Neath Port Talbot hospital between January 2019 and June 2024. The accuracy of any outputs are dependent on the quality of data entered into to SBUHB bed

management tool. Ward types are classified as Antenatal, Labour, Midwife-led, NICU, Postnatal and Triage. There were an average of 87.2 beds available across all ward types over the analysis period.

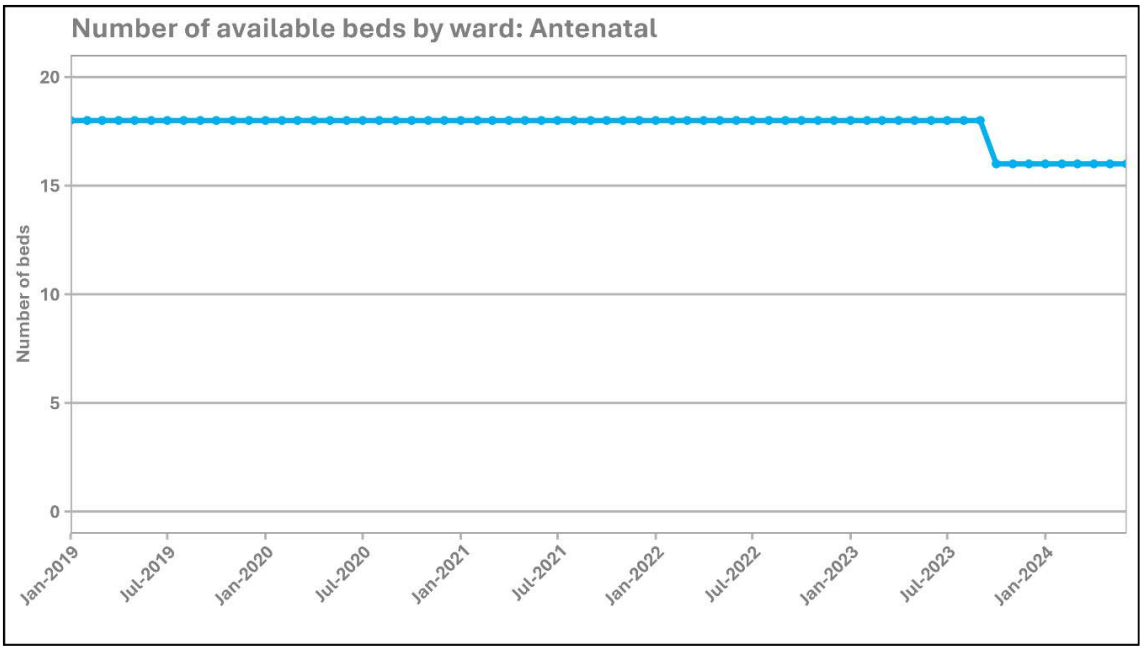


22. Number of allocated beds on maternity or neonatal wards: Triage (January 2019 to June 2024)

Between January 2019 and September 2023 there were 3 beds on the obstetric triage ward at Singleton Hospital, which increased to 5 beds from October 2023 onwards.

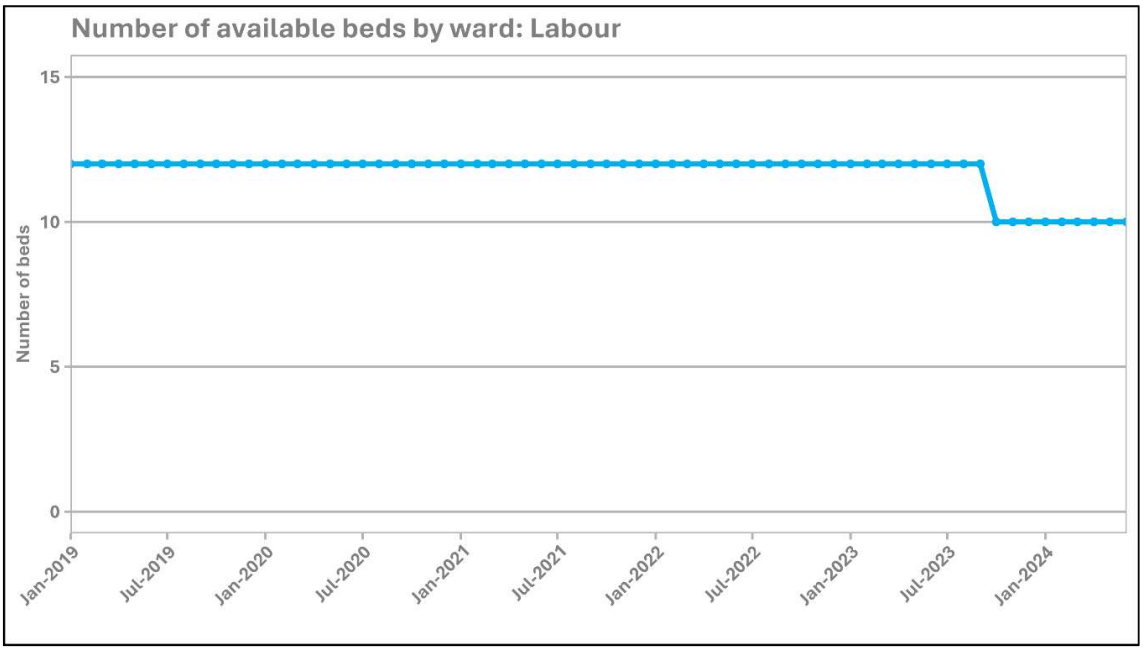
23. Number of allocated beds for patients on maternity or neonatal wards: Antenatal (January 2019 to June 2024)

Between January 2019 and September 2023 there were 18 beds on the antenatal ward at Singleton Hospital, which decreased to 16 beds from October 2023 onwards.



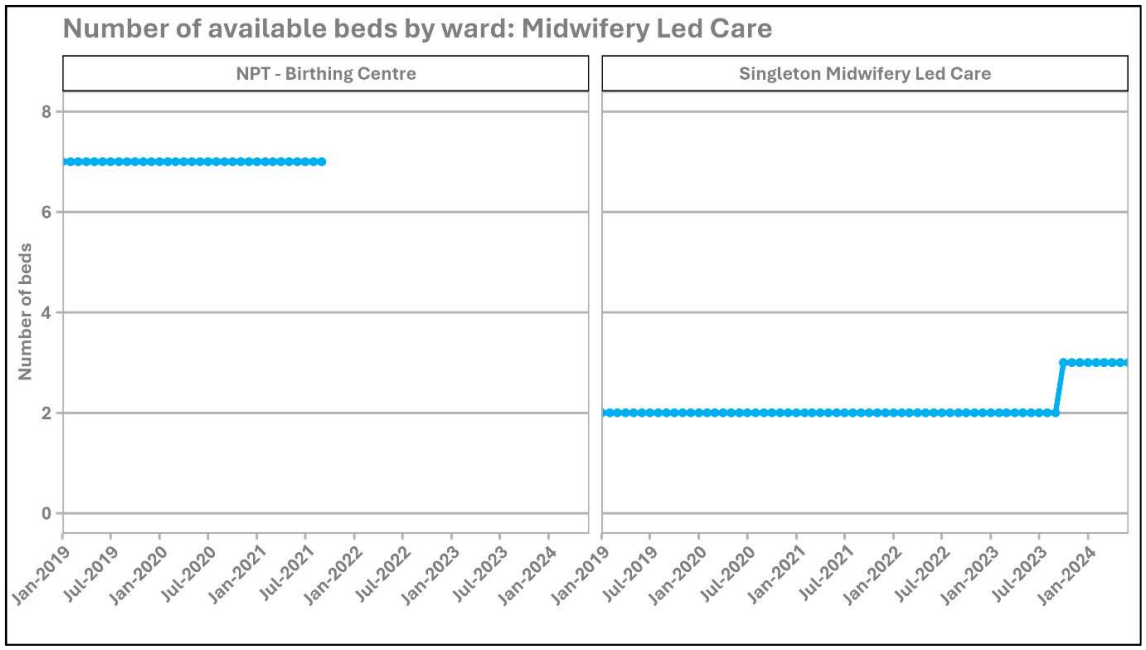
24. Number of allocated beds for patients on maternity or neonatal wards: Labour Ward (January 2019 to June 2024)

Between January 2019 and September 2023 there were 12 beds on the labour ward at Singleton Hospital, which decreased to 10 beds from October 2023 onwards.



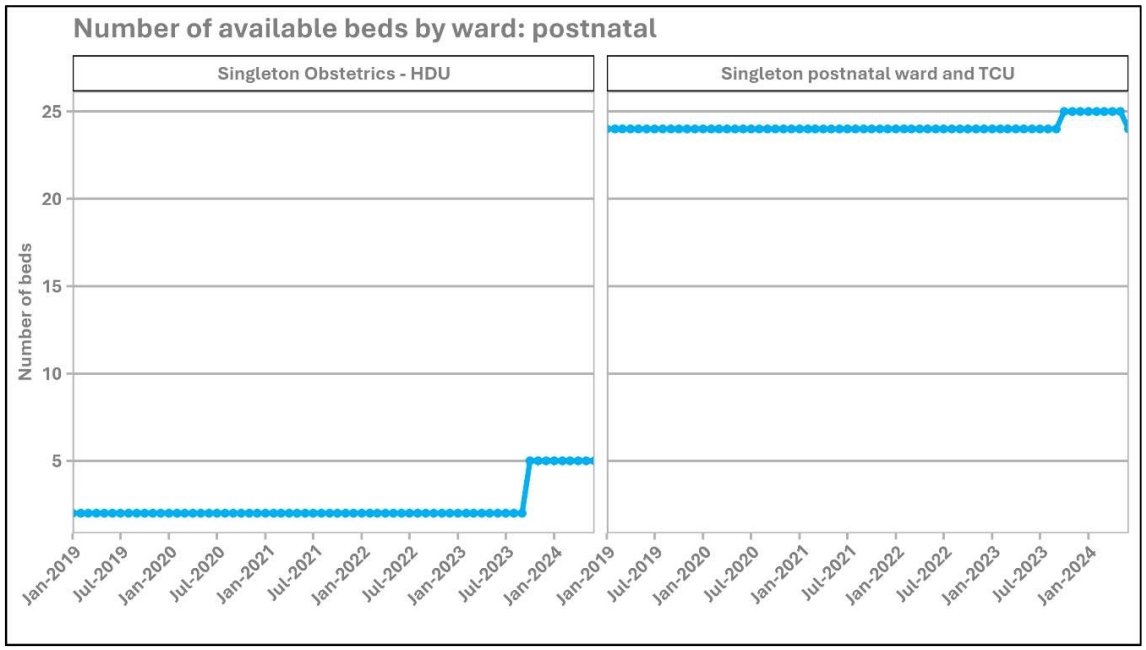
25. Number of allocated beds for patients on maternity or neonatal wards: Midwifery Led Units (January 2019 to June 2024)

The unit at Neath Port Talbot Hospital closed on approximately the 16th of September 2021 but had 7 beds prior to closure. The midwifery-led unit at Singleton Hospital had 2 beds between January 2019 and September 2023, increasing to 3 beds from October 2023 onwards.



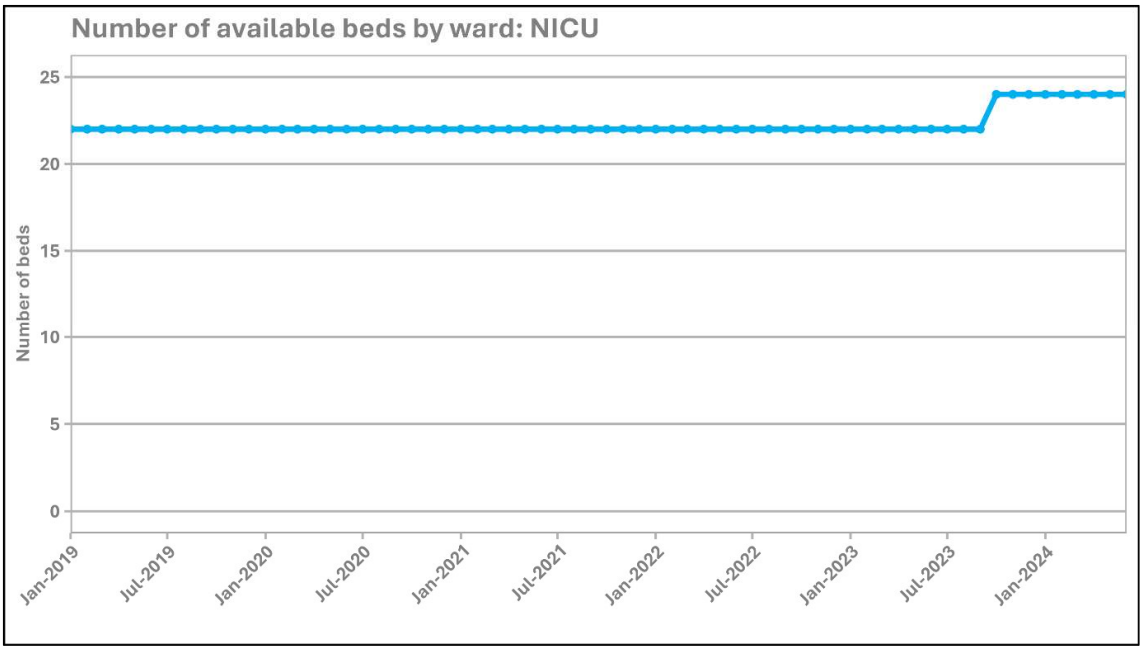
26. Number of allocated beds for patients on maternity or neonatal wards: Postnatal Ward (January 2019 to June 2024)

The postnatal ward at Singleton Hospital moved from Ward 18 to Ward 20 in October 2020, and improvements in data capture meant that beds data for transitional care were recorded from October 2023 onwards (whereas previously these were recorded under Ward 20). There were an average of 24.1 postnatal beds available (Ward 18, Ward 20 and transitional care) between January 2019 and June 2024, and average of 2.4 high dependency beds.



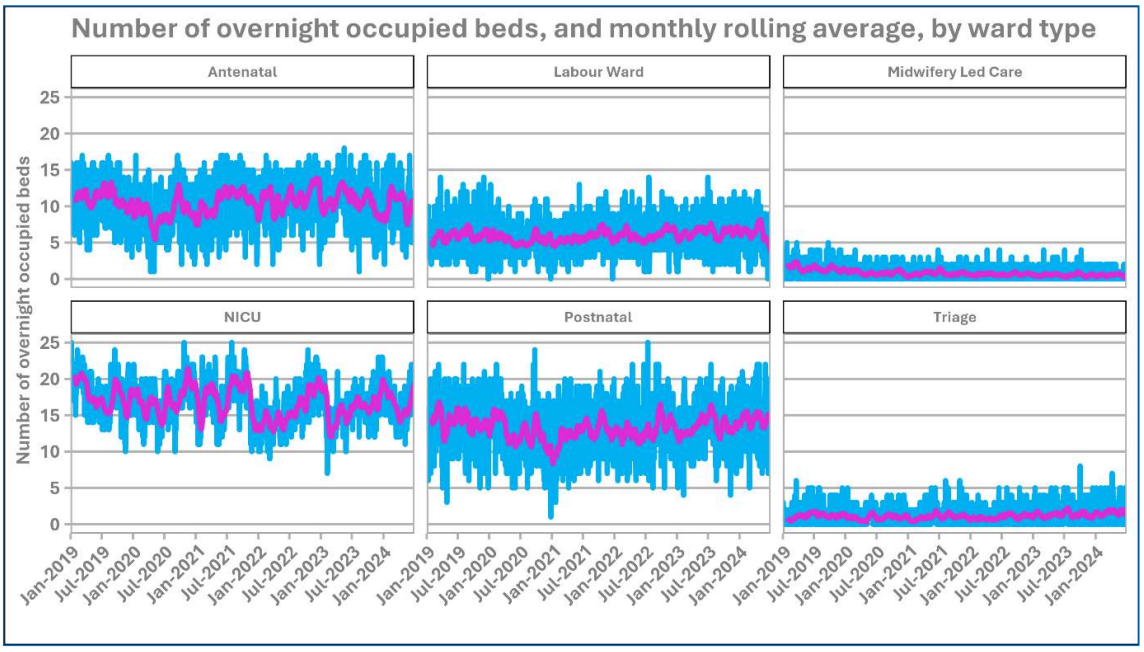
27. Number of allocated beds for patients on maternity or neonatal wards: NICU (January 2019 to June 2024)

Between January 2019 and September 2023 there were 22 beds on the NICU at Singleton Hospital, which increased to 24 beds from October 2023 onwards.



28. Number of occupied beds on maternity or neonatal wards by type of ward (January 2019 to June 2024)

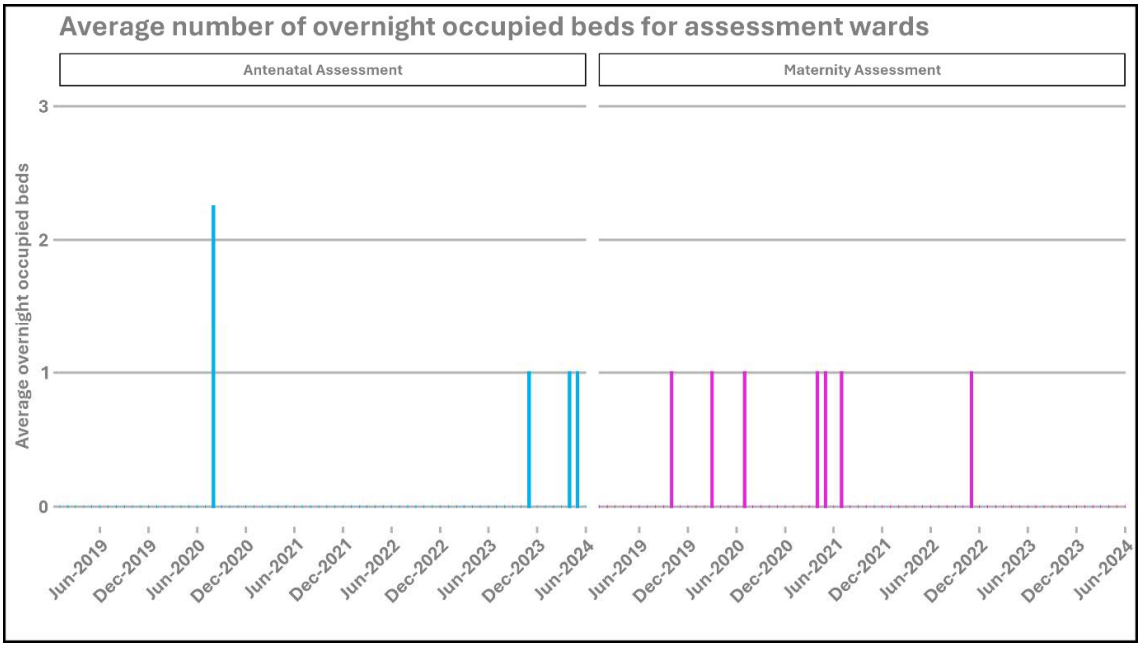
The average overnight bed occupancy between January 2019 and June 2024 for each ward type were: **10.5** overnight occupied beds for the antenatal ward, **5.9** occupied beds for the labour ward, **1.0** occupied beds for midwifery led care prior to the closure of the Birth Centre at NPT and **0.6** occupied beds after the closure, **16.8** occupied beds for NICU, **13.3** occupied beds for postnatal wards, and **1.1** occupied beds for the triage ward.



29. Average number of occupied beds for patients on assessment wards (January 2019 to June 2024)

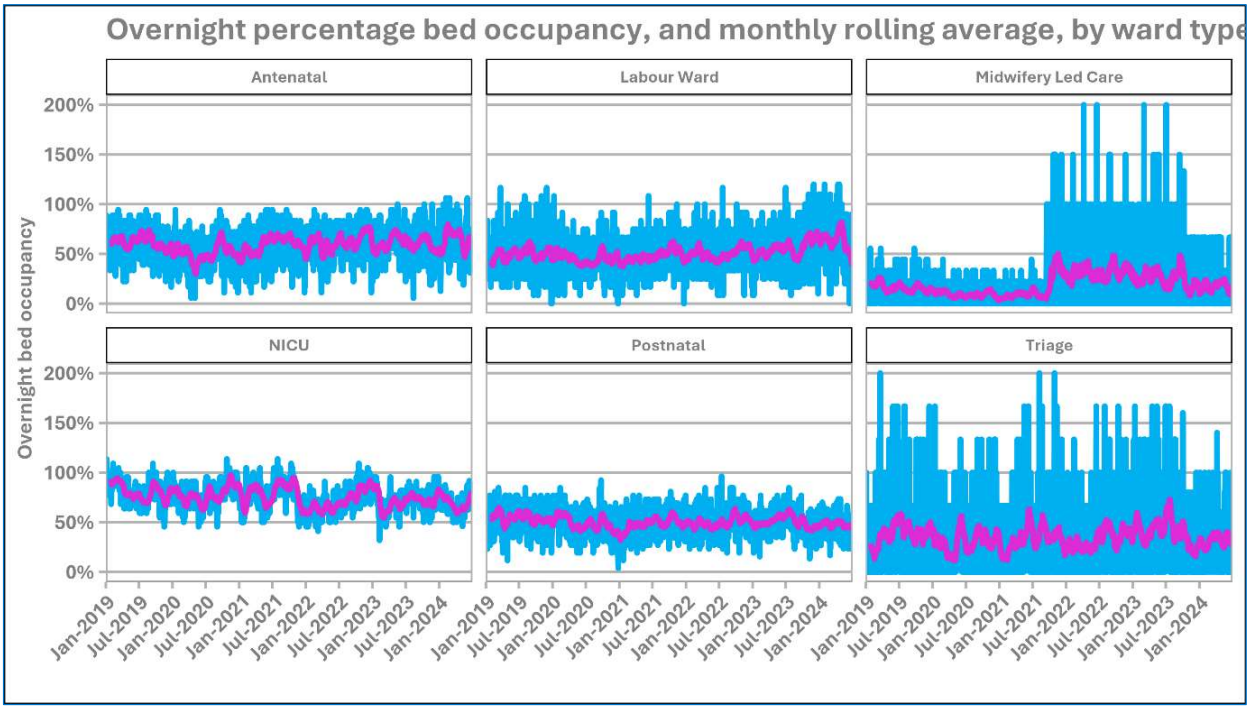
Patients do not tend to stay overnight on the assessment wards, and there is no bed capacity as such, however there were occasions where ward activity was recorded overnight in these areas. This could be a recording issue, or indicative of occasions where the hospital was particularly busy. Patients were recorded overnight in August 2020, November 2023, April 2024 and May 2024 on the Antenatal

Assessment Ward, whilst patients were recorded overnight in October 2019, March 2020, July 2020, April 2021, May 2021, July 2021 and November 2022 on the maternity assessment ward.



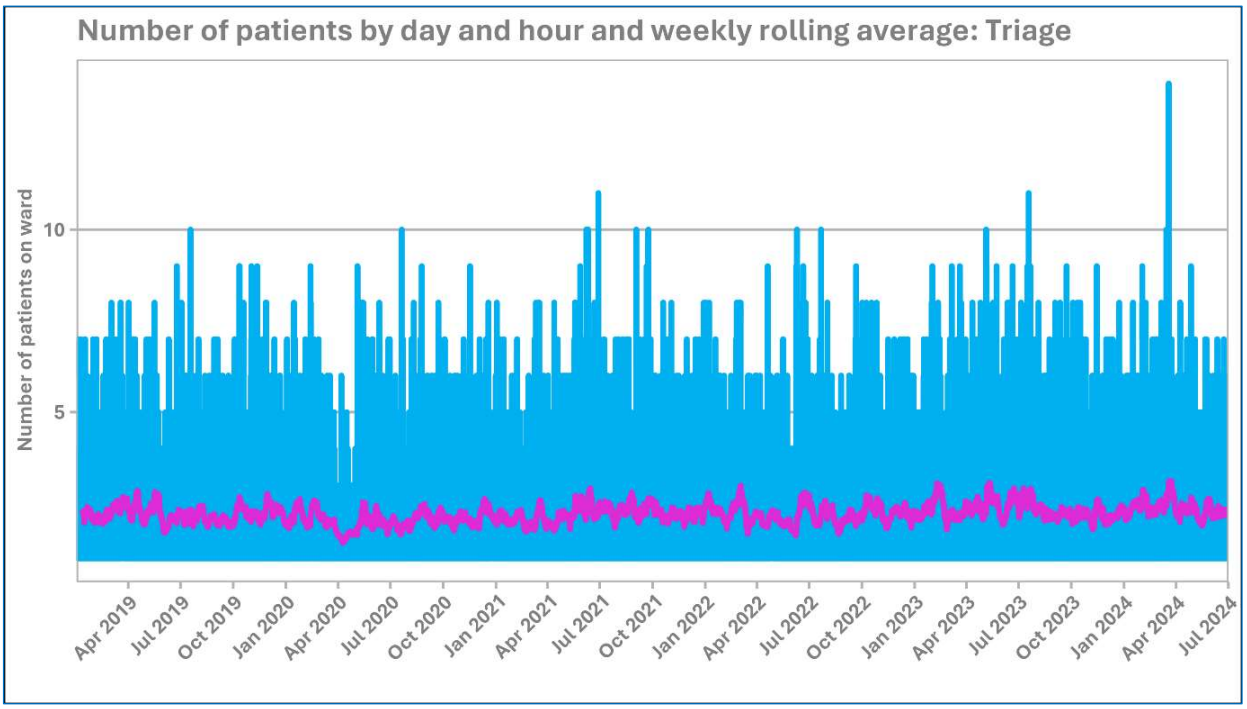
30. Overnight bed occupancy rate by type of ward (January 2019 to June 2024)

The average overnight bed occupancy rates between January 2019 and June 2024 for each ward type were: **59.2%** for the antenatal ward, **50.5%** for the labour ward, **11.5%** for midwifery led care prior to the closure of the Birth Centre at NPT and **25.8%** after the closure, **75.3%** for NICU, **49.9%** for the postnatal wards, and **34.3%** for the triage ward. It is important to note these figures are just snapshots at midnight and may not reflect how busy a ward was during the day. The midwifery led care and triage wards are short lengths of stay wards with relatively quick turnarounds so high occupancy figures should be interpreted with caution.



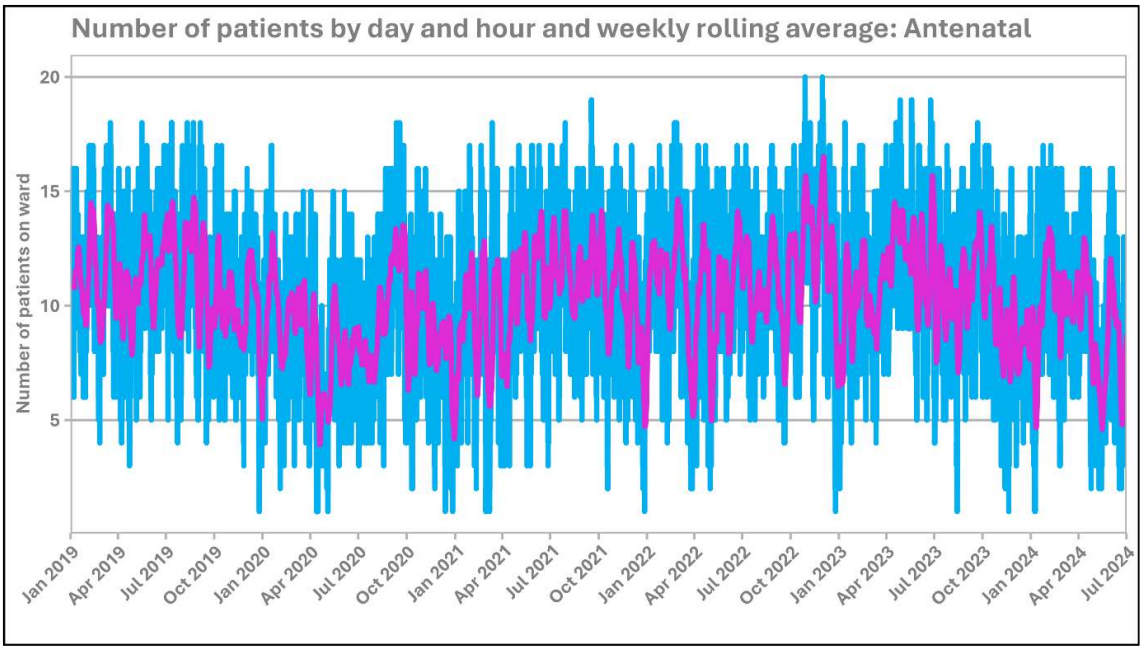
31. Number of patients on ward by day and hour: AAU/Triage

The average number of patients across all hours between January 2019 and June 2024 was **2.2**, providing an average hourly occupancy of **67.9%** (compared to 34.3% when looking at overnight occupancy only). However, this varied significantly with a maximum of **14** patients at one point, and a minimum of 1. There were **4,782** occasions recorded where the number of patients on the ward exceeded available beds (or **9.9%** of all recorded hourly snapshots).



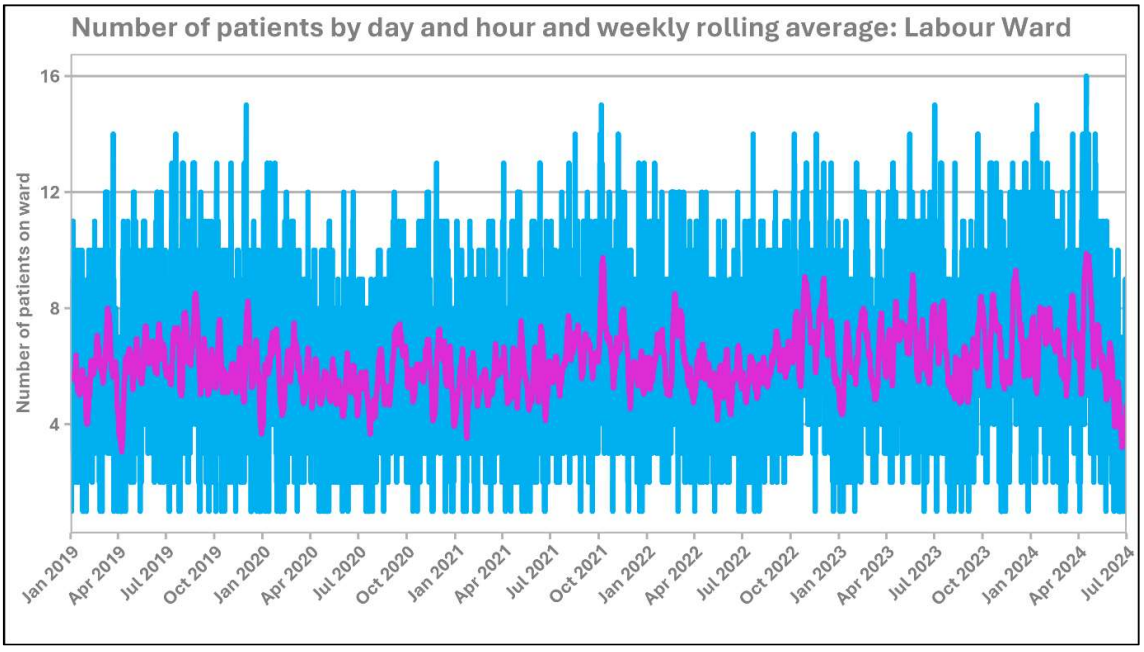
32. Number of patients on ward by day and hour: Antenatal Ward

The average number of patients across all hours between January 2019 and June 2024 was **10.3**, providing an average hourly occupancy of **58.3%** (compared to 59.2% when looking at overnight occupancy only). However, this varied significantly with a maximum of **20** patients at one point, and a minimum of 1. There were **32** occasions recorded where the number of patients on the ward exceeded available beds (or **0.1%** of all recorded hourly snapshots), occurring mainly in 2022 and 2023.



33. Number of patients on ward by day and hour: Labour Ward

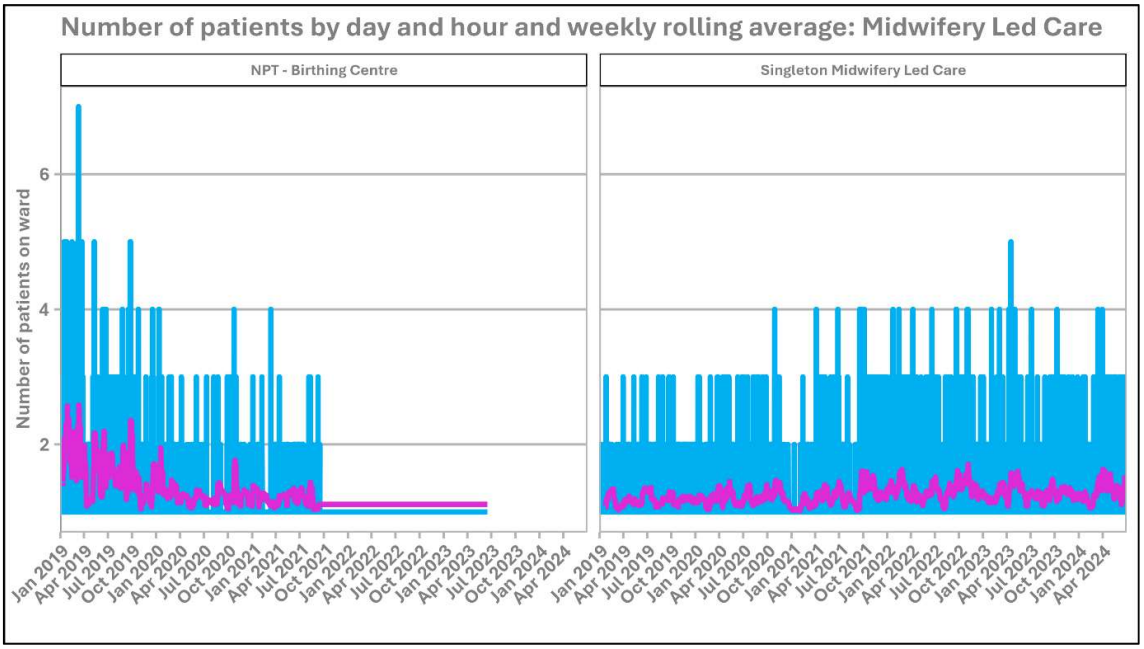
The average number of patients across all hours between January 2019 and June 2024 was **6.1**, providing an average hourly occupancy of **52.4%** (compared to 50.5% when looking at overnight occupancy only). However, this varied significantly with a maximum of **16** patients at one point, and a minimum of 1. There were **558** occasions recorded where the number of patients on the ward exceeded available beds (or **1.2%** of all recorded hourly snapshots) – this issue appeared to get worse towards the end of the data period, with demand exceeding capacity on **187** occasions in 2023 and **276** times in the first 6 months of 2024 (nearly half the total number of occasions).



34. Number of patients on ward by day and hour: Midwifery-Led Units

The unit at Neath Port Talbot Hospital closed in mid-September 2021. As shown below, the average number of patients across all hourly snapshots between January 2019 and June 2024 was **1.5** giving an average hourly occupancy of **20.8%**. There were no recorded instances of the number of patients exceeding bed capacity.

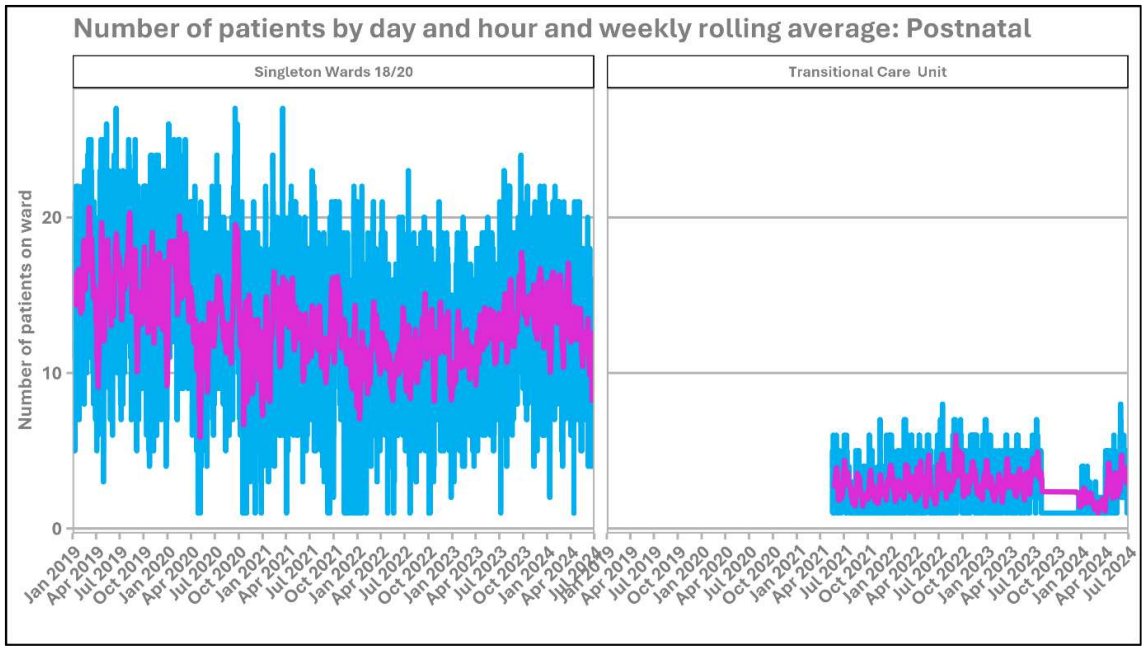
The average number of patients between January 2019 and June 2024 for the Singleton midwifery-led unit was **1.3**, giving an average occupancy of **58.8%**. However, this varied with a maximum of **5** patients at one point, and a minimum of 1. There were **516** occasions recorded where the number of patients on the ward exceeded available beds (**1.1%** of all recorded hourly snapshots).



35. Number of patients on ward by day and hour: Postnatal Ward

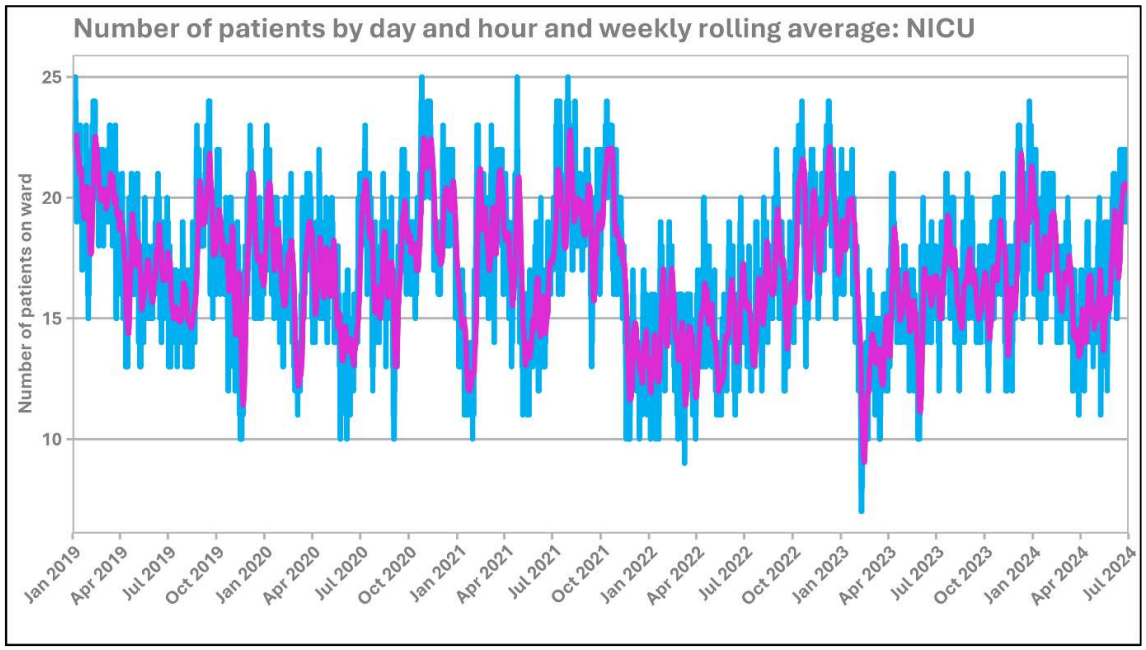
The average number of patients between January 2019 and June 2024 for Wards 18 and 20 was **13.3** giving an average hourly occupancy of **64.6%**. However, this varied significantly with a maximum of **27** patients at one point, and a minimum of 1. There were **992** occasions recorded where the number of patients on the ward exceeded available beds (or **2.1%** of all hourly snapshots). This issue appeared to get worse towards the end of the data period, with demand exceeding capacity on **356** occasions in 2023 and **228** times in the first 6 months of 2024.

The average number of patients in the Transitional Care Unit (which started recording activity from May 2021 onwards) was **2.9** giving an average hourly occupancy of **40.8%**. There was a maximum of **8** patients at one point. There were **7** occasions recorded where the number of patients on the ward exceeded available beds (**0.03%** of all hourly snapshots).



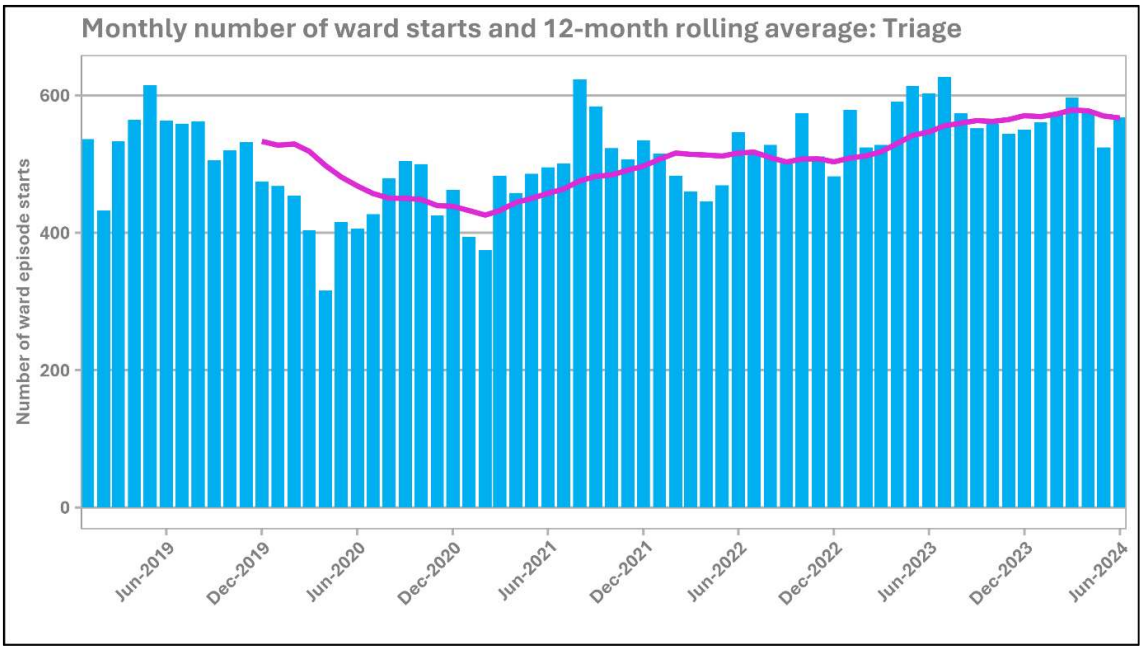
36. Number of patients on ward by day and hour: NICU

The average number of patients between January 2019 and June 2024 was **16.9**, providing an average hourly occupancy of **75.9%** (compared to 75.3% when looking at overnight occupancy only). However, this varied significantly with a maximum of **25** patients at one point, and a minimum of **7**. There were **1,017** occasions recorded where the number of patients on the ward exceeded available beds (or **2.1%** of all hourly snapshots). This issue appeared to improve towards the end of the data period, with no occasions of demand exceeding capacity recorded in 2023 or the first 6 months of 2024.



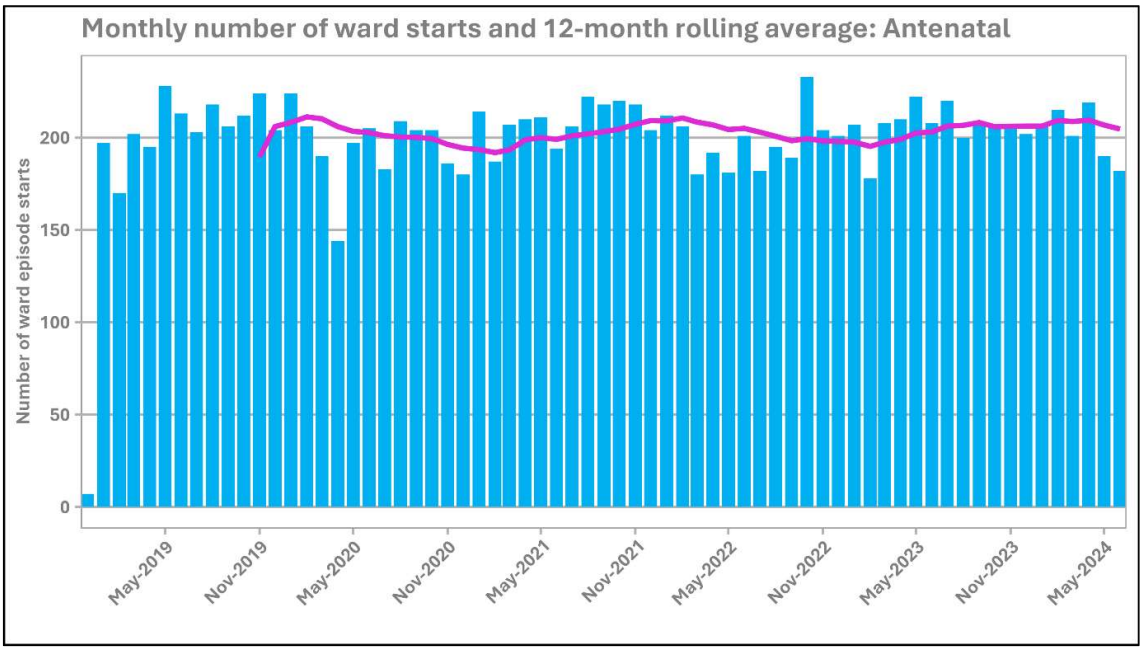
37. Monthly ward activity for maternity and neonatal wards: AAU/Triage (January 2019 to June 2024))

There were **33,902** ward episode starts on the AAU/Triage ward between January 2019 and June 2024, with an average of **513.7** ward starts per month.



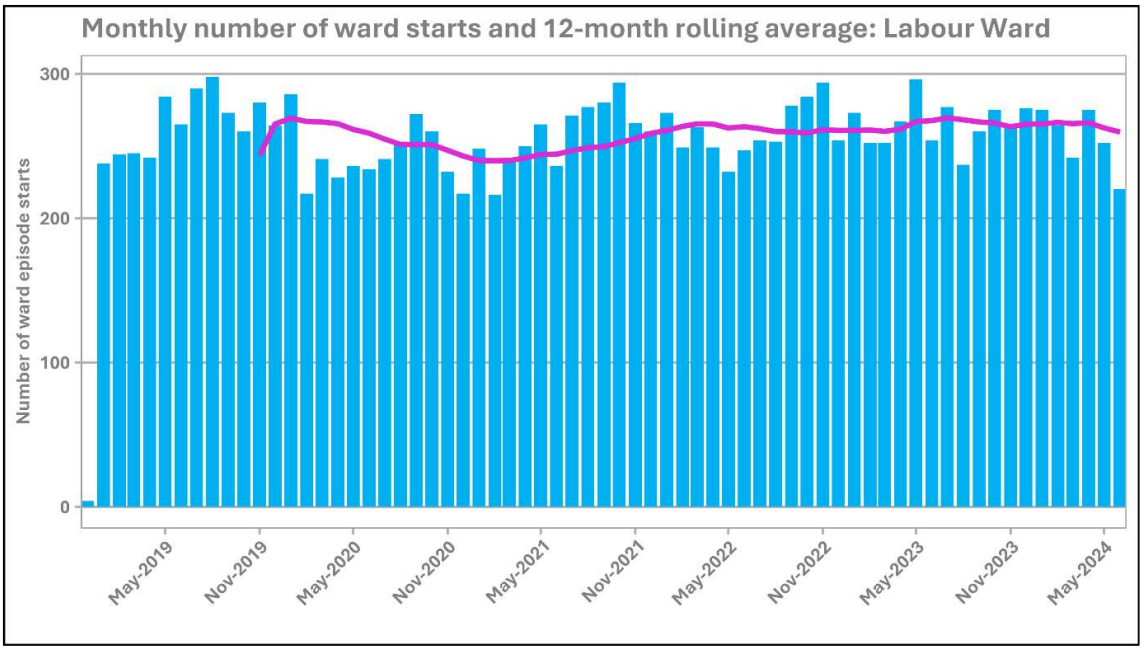
38. Monthly ward activity for maternity and neonatal wards: Antenatal Ward (January 2019 to June 2024)

There were **13,387** ward episode starts on the antenatal ward between January 2019 and June 2024, with an average of **199.8** ward starts per month.



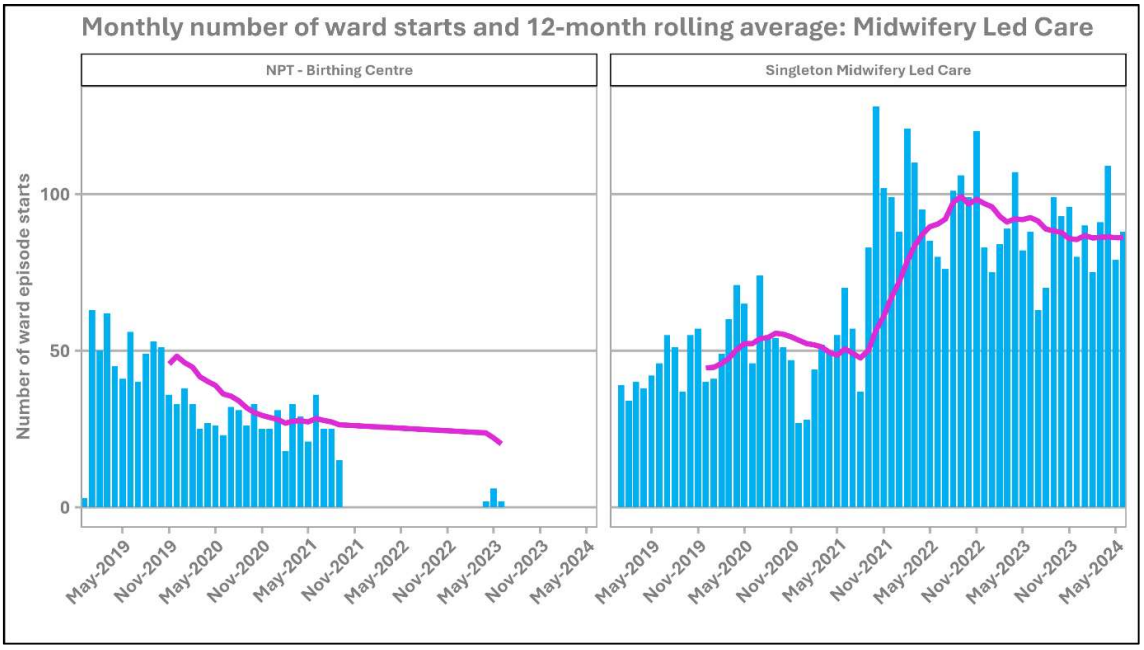
39. Monthly ward activity for maternity and neonatal wards: Labour Ward(January 2019 to June 2024))

There were **17,049** ward episode starts on the labour ward between January 2019 and June 2024, with an average of **254.5** ward starts per month.



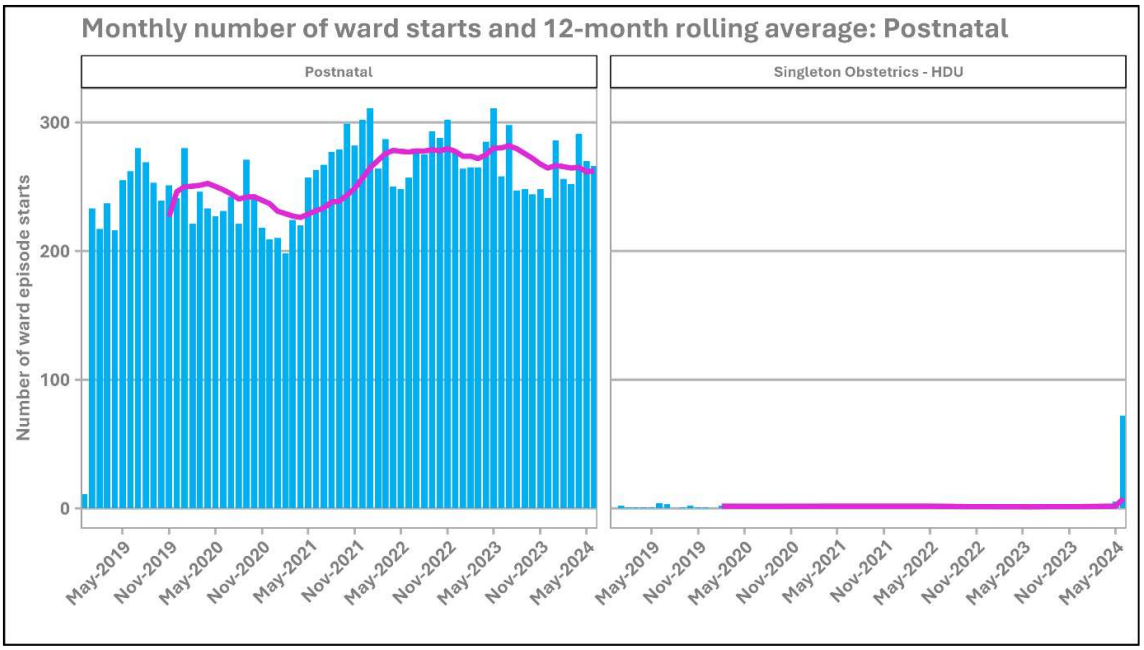
40. Monthly ward activity for maternity and neonatal wards by individual ward and type of ward: Midwifery Led Units (January 2019 to June 2024))

There were **1,169** ward episode starts at the NPT midwifery-led unit between January 2019 and September 2021, when the unit closed, with an average of **31.6** ward starts per month. There were a total of **4,701** ward episode starts at the Singleton Birth Centre between January 2019 and June 2024, with an average of **71.2** ward starts per month.



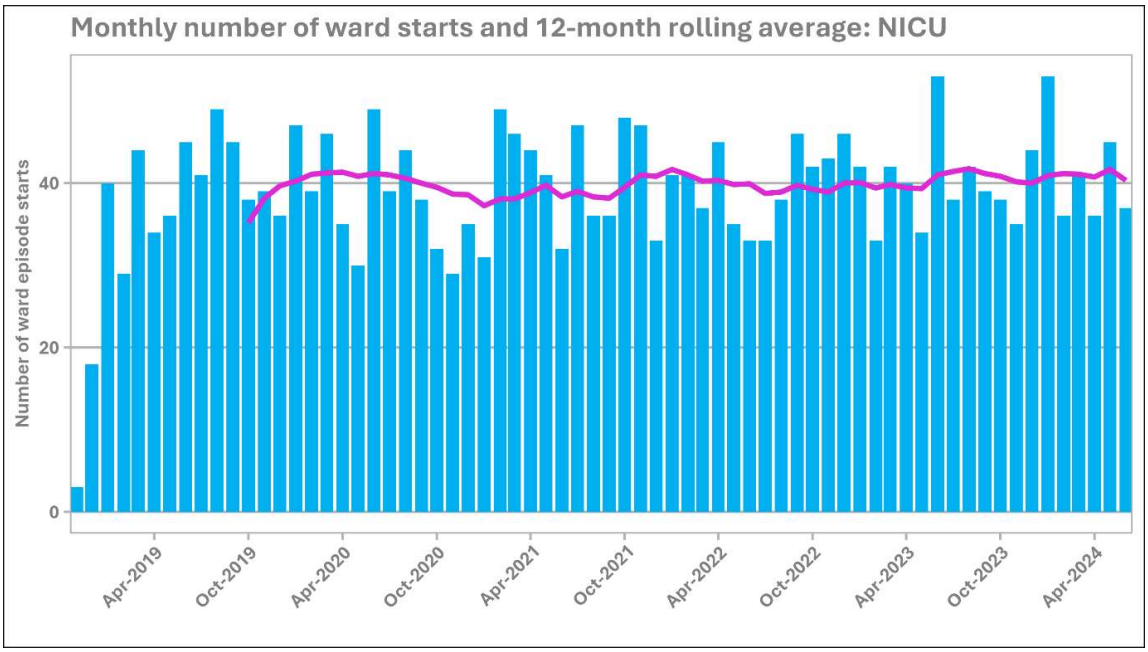
41. Monthly ward activity for maternity and neonatal wards: Postnatal Ward(January 2019 to June 2024))

There were **17,008** ward episode starts on the postnatal wards (wards 18 and 20, and transitional care unit) between January 2019 and June 2024, with an average of **253.8** ward starts per month.



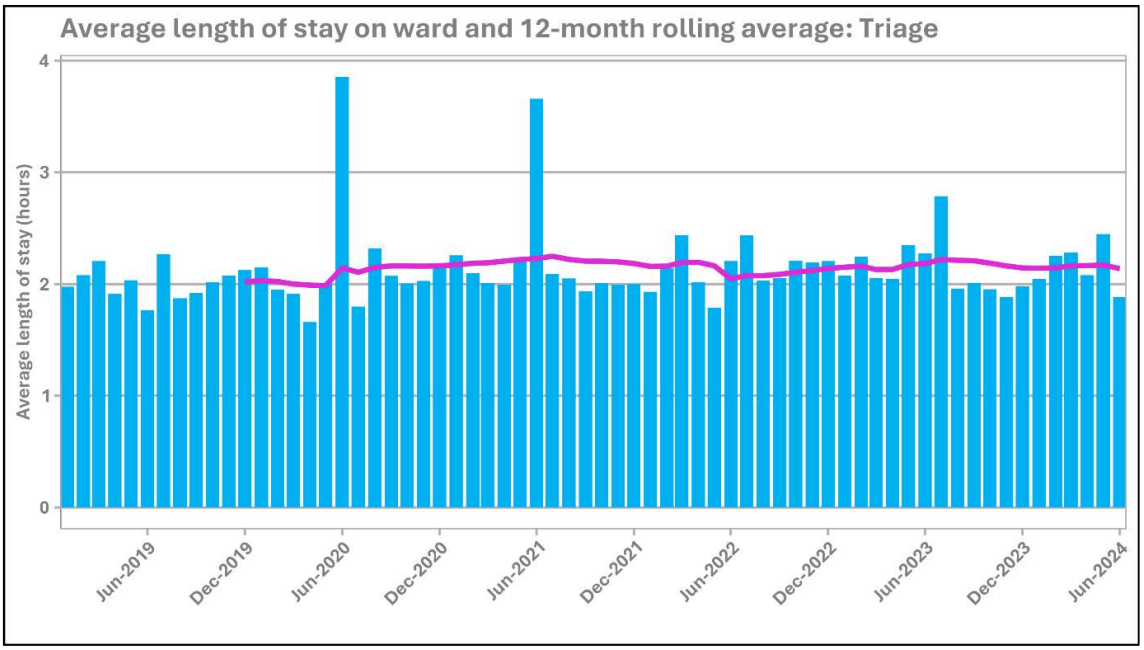
42. Monthly ward activity for maternity and neonatal wards: NICU (January 2019 to June 2024))

There were 2,658 ward episode starts on NICU between January 2019 and June 2024, with an average of 39.1 ward starts per month.



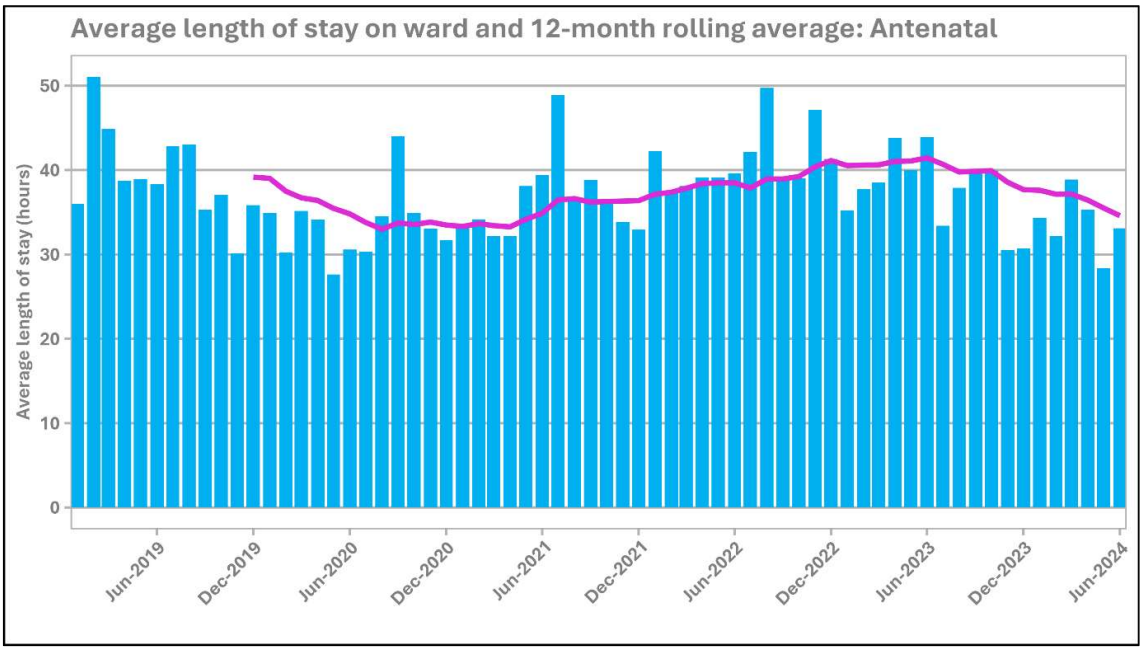
43. Average length of stay by month for maternity and neonatal wards: AAU/Triage (January 2019 to June 2024)

The average length of stay on the AAU/Triage between January 2019 and June 2024 was **2.1** hours.



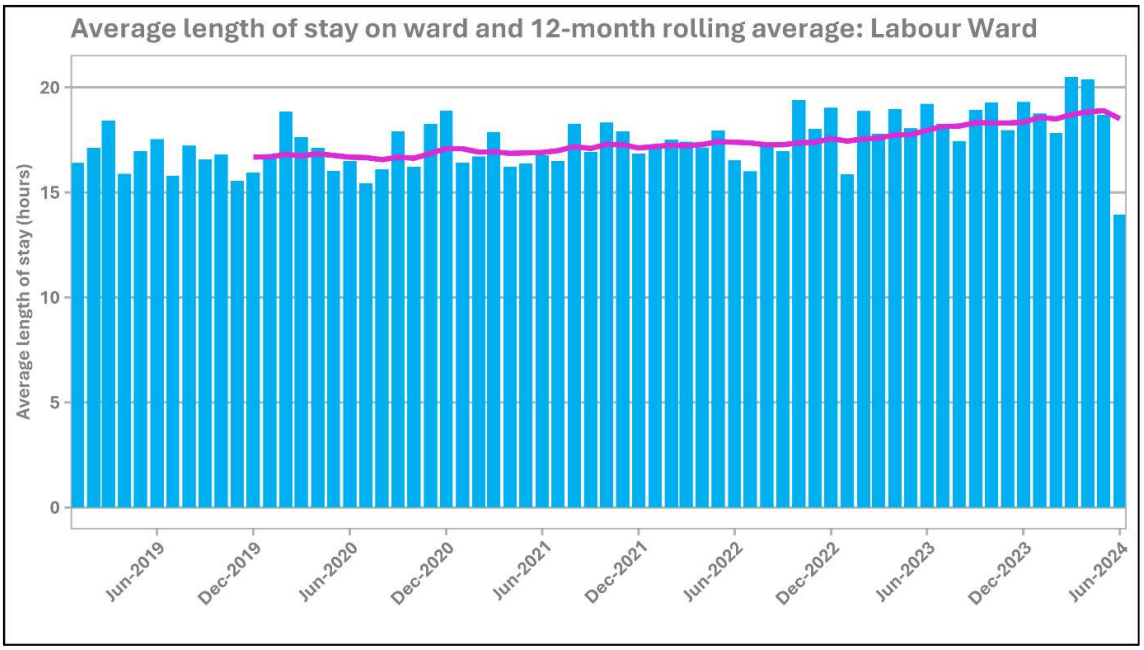
44. Average length of stay by month for maternity and neonatal wards: Antenatal Ward (January 2019 to June 2024)

The average length of stay on the antenatal ward between January 2019 and June 2024 was **37.2** hours (or **1.6** days).



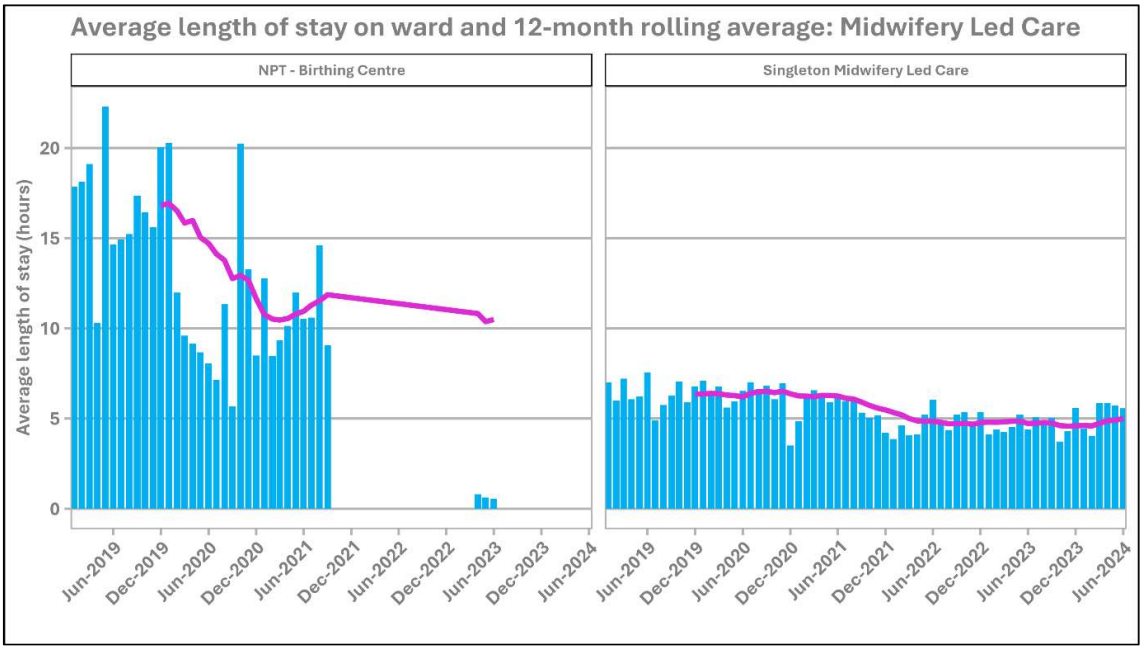
45. Average length of stay by month for maternity and neonatal wards: Labour Ward (January 2019 to June 2024)

The average length of stay on the labour ward between January 2019 and June 2024 was **17.5** hours.



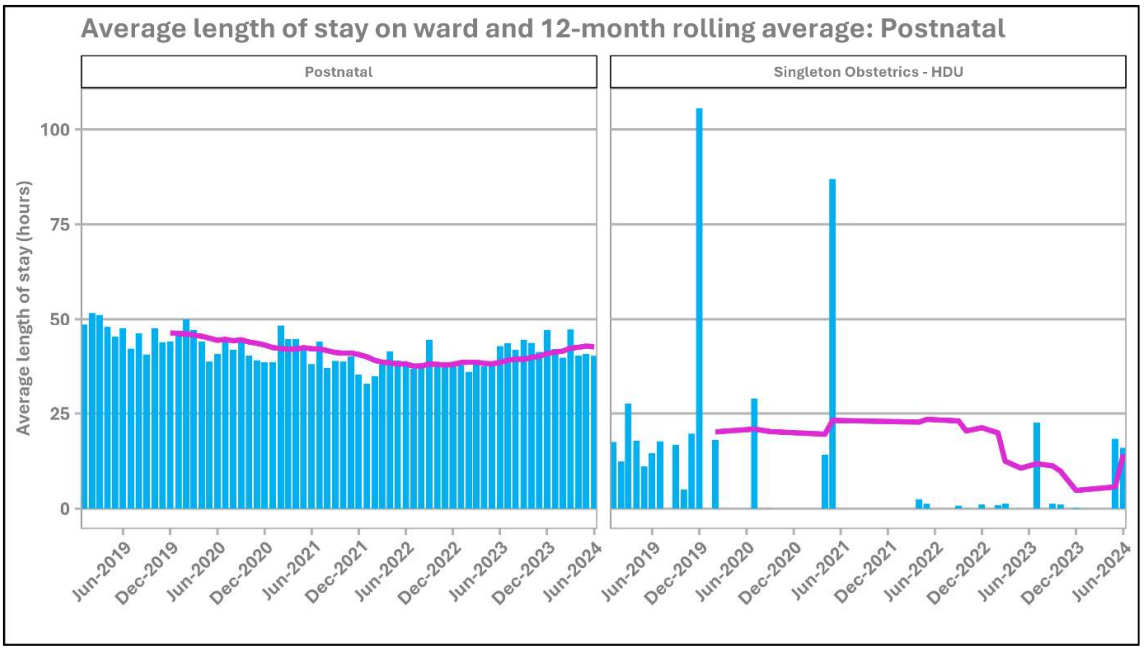
46. Average length of stay by month for maternity and neonatal : Midwifery-Led Units (January 2019 to June 2024)

The average length of stay on the NPT midwifery-led unit between January 2019 and September 2021, when the unit closed, was **14.0** hours. The average length of stay on the Singleton midwifery-led unit between January 2019 and June 2024 was **5.3** hours.



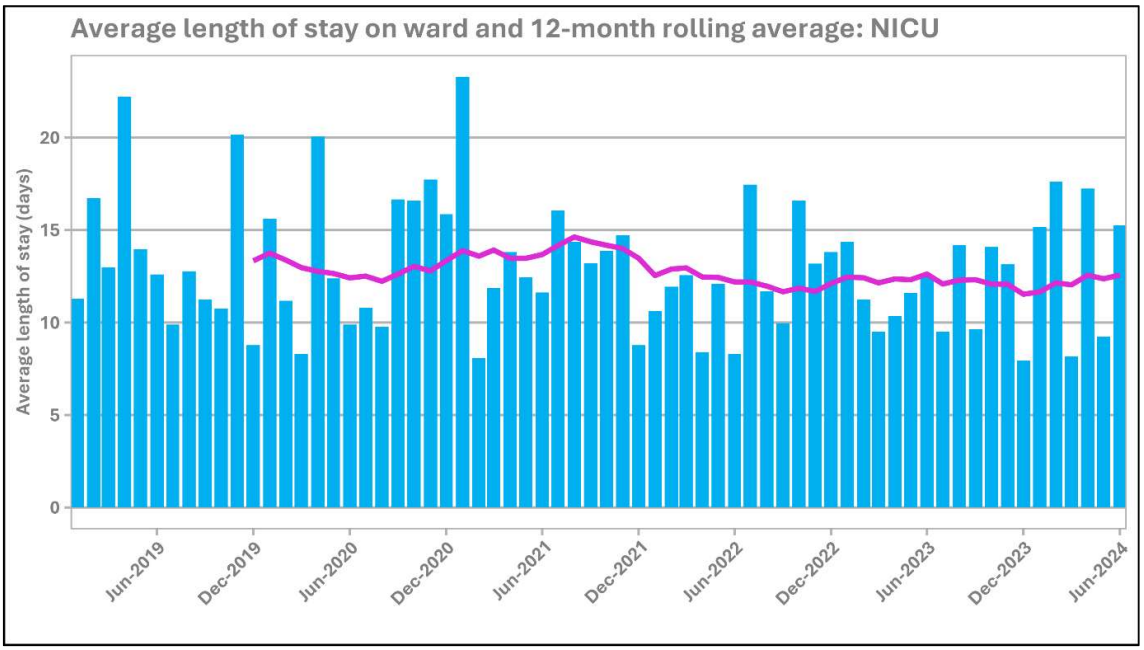
47. Average length of stay by month for maternity and neonatal wards: Postnatal Ward (January 2019 to June 2024)

The average length of stay on the postnatal area (wards 18 and 20, and transitional care unit) between January 2019 and June 2024 was **41.5** hours (or 1.7 days).



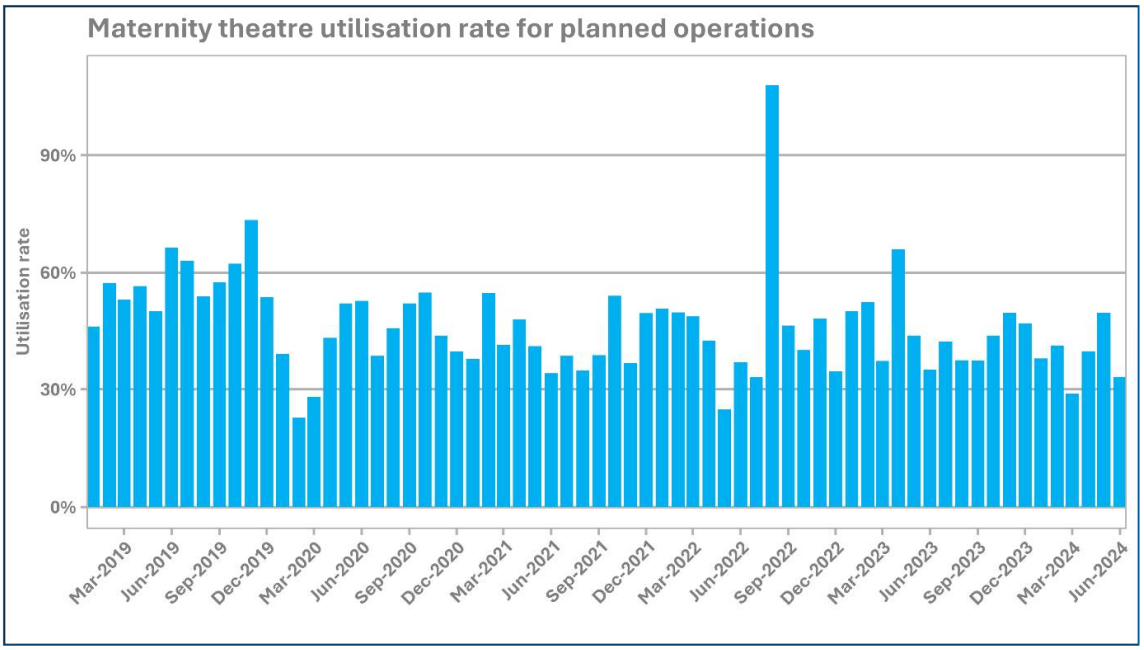
48. Average length of stay by month for maternity and neonatal wards: NICU (January 2019 to June 2024)

The average length of stay on NICU between January 2019 and June 2024 was **12.9** days (this analysis is to June 2024 – earlier analysis in this appendix was to March 2024).



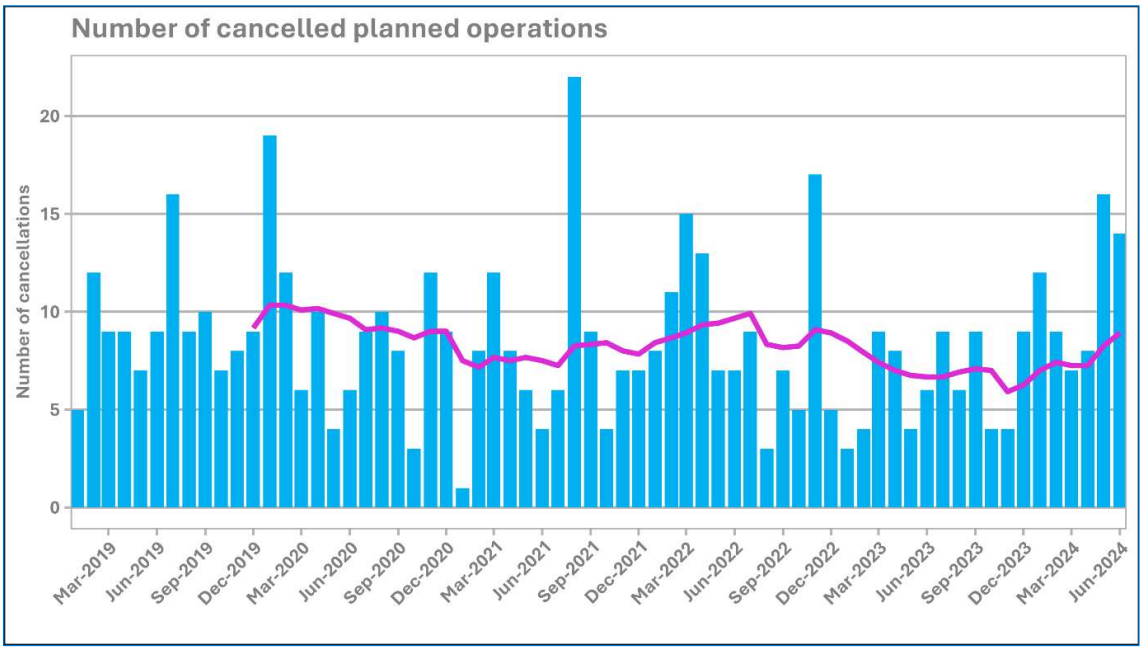
49. Maternity theatre utilisation rates for planned operations (January 2019 to June 2024)

The theatre utilisation rate is defined as the total time between the first anaesthetics starting on the first patient in a session to the last patient leaving theatre in the session, divided by the planned session time (including cancelled sessions) for a particular month. The average utilisation rate over the period was **46.2%**. Utilisation data was not available for unplanned operations, nor for daily maternity theatre slots planned.



50. Maternity theatre planned operation cancellations (January 2019 to June 2024)

The chart below shows the number of planned maternity operations cancelled at any point before the procedure. There were an average of **8.5** cancelled planned operations per month between January 2019 and June 2024.



D. Outcomes and quality metrics

51. Findings from MBRRACE-UK site-specific reports for SBUHB, 2018 – 2023

The table below summarises the number of stillbirths and neonatal deaths for SBUHB between 2018 and 2022, using results obtained from the MBRRACE-UK perinatal mortality surveillance reports which are produced for all Trusts and Health Boards across the UK. Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies.

Stillbirths are defined as babies delivered at or after 24 weeks gestational age showing no signs of life, irrespective of when the death occurred. Neonatal deaths are defined as live born babies who died before 28 completed days after birth. Extended perinatal deaths are defined as either a stillbirth or neonatal death.

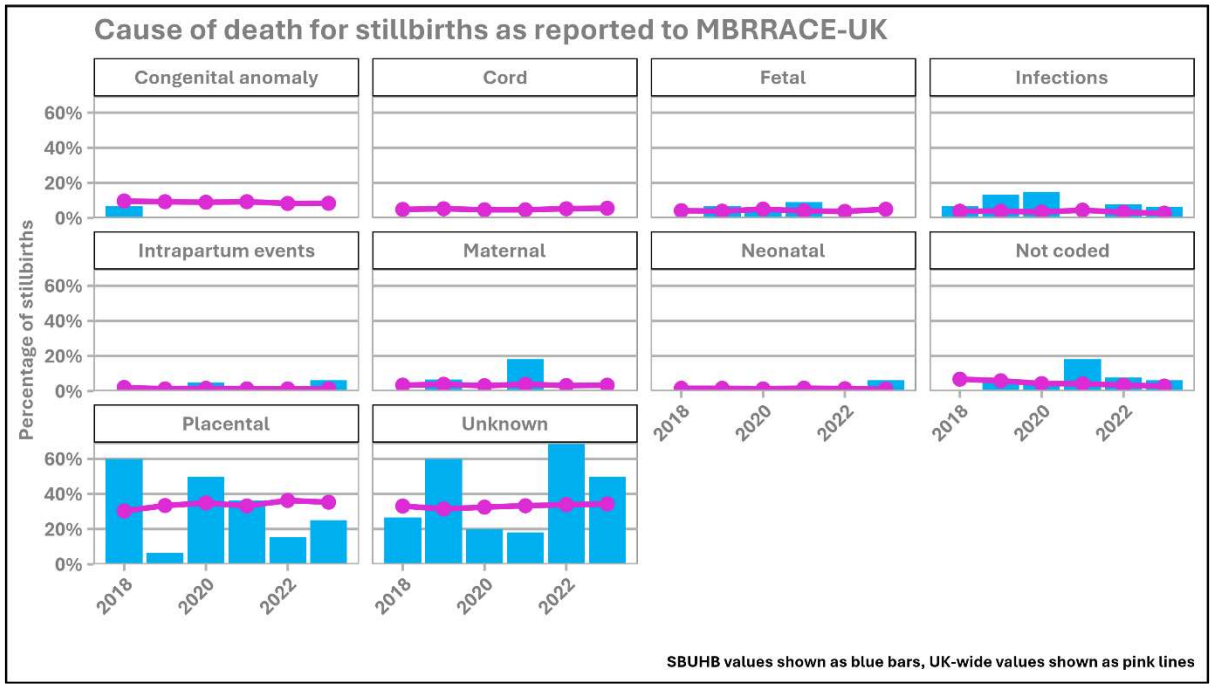
Stabilised and adjusted mortality rates (accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and, for neonatal deaths only, gestational age at birth) are presented to account for differences in case mix when comparing between organisations and provide a more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

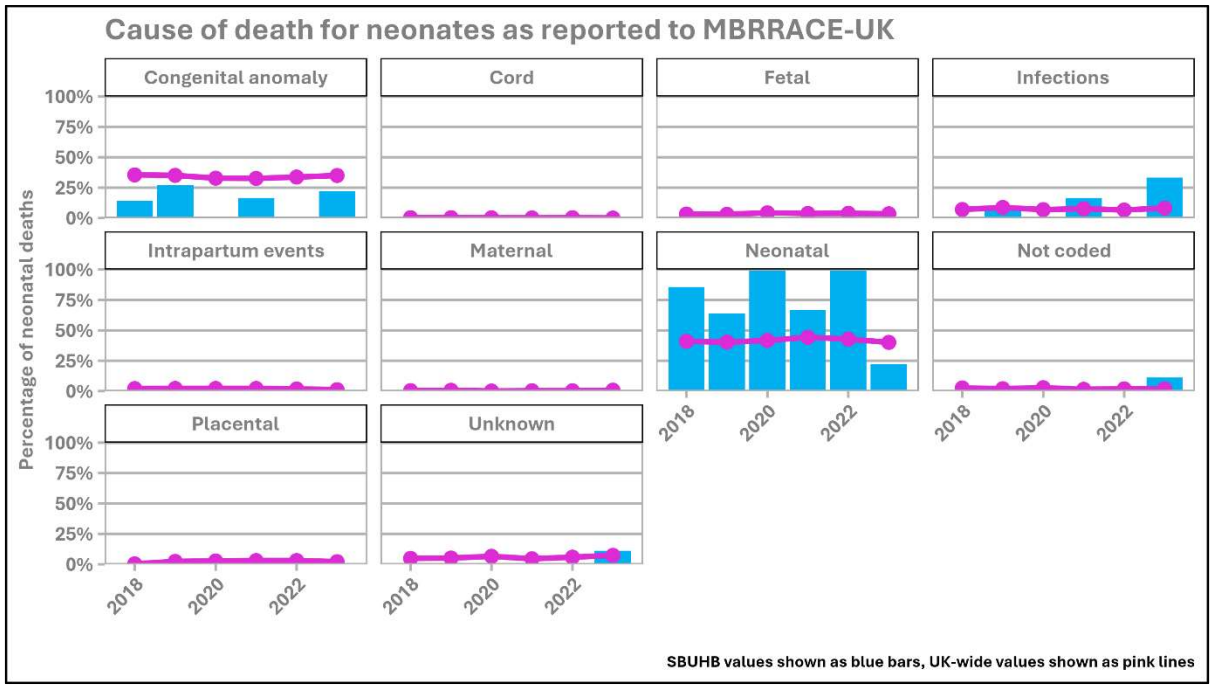
	Type of death, with stabilised & adjusted mortality rate (with 95% confidence interval)		
Year	**Stillbirth**	**Neonatal**	**Extended Perinatal**
2018	**4.02** (3.25 to 5.00)	**1.98** (1.25 to 3.15)	**5.99** (4.95 to 7.61)
2019	**4.04** (3.43 to 4.97)	**2.24** (1.35 to 3.65)	**6.32** (5.34 to 8.32)
2020	**4.34** (3.34 to 6.00)	**1.52** (0.98 to 2.34)	**5.82** (4.72 to 7.91)
2021	**3.86** (3.00 to 4.98)	**2.46 (1.55 to 3.79)**	**6.38 (5.28 to 8.47)**
2022	**3.64 (3.11 to 4.29)**	**1.62 (0.97 to 2.57)**	**5.27 (4.55 to 6.52)**
2023	**3.73 (3.03 to 4.80)**	**2.10 (1.35 to 3.21)**	**5.87 (4.84 to 7.76)**

The MMBRACE-UK benchmarking data shows that between 2018 and 2023:

- SBUHB was an outlier on stillbirth rates in 2020, with the stabilised and adjusted mortality rate more than 5% higher than the average of similar Trusts and Health Boards.
- SBUHB was an outlier on neonatal mortality rates in 2019, 2021, and 2023 with the Health Board's stabilised and adjusted mortality rate more than 5% higher than similar Trusts and Health Boards in those years.
- Related to the above, SBUHB was an outlier on stabilised and adjusted extended perinatal mortality rates (which combine stillbirths and neonatal mortality) for three consecutive years between 2019 and 2021, and also in 2023, with extended perinatal mortality rates 5% higher than the average for similar Health Boards for those years. This was driven by a higher than expected stillbirth rate in 2020, and higher than expected neonatal mortality rates in 2019, 2021 and 2023.
- In 2018 and 2022 the stabilised and adjusted mortality rates for stillbirths, neonatal deaths and extended perinatal deaths were similar to, or lower than, the average for comparator Trusts and Health Boards
- From 2021 onwards MBRRACE-UK included additional mortality metrics, which calculate the stillbirth, neonatal, and perinatal mortality rates for organisations but exclude deaths due to congenital anomalies. When excluding deaths due to congenital abnormalities, SBUHB is also classed as an outlier for stillbirths in 2023, meaning that for this year (the latest year of data available) SBUHB was an outlier for stillbirths, neonatal mortality, and extended perinatal mortality, with stabilised and adjusted rates more than 5% higher than the average of similar Trusts and Health Boards

Causes of death are reported to MBRRACE-UK using the Cause of Death & Associated Conditions (CODAC) classification system[1] https://pubmed.ncbi.nlm.nih.gov/19515228/ . The following two charts provide an illustration of SBUHB reported cause of death data with UK-wide data.





The commentary below should be interpreted with caution as the degree of inconsistency in the percentage rates between years for SBUHB is indicative of the low absolute numbers of stillbirths and neonatal deaths which occurred.

For **stillbirths**:

- Across the UK, the cause of death for over a third of stillbirths was recorded as 'not known.' This has been a consistent pattern over the period from 2018 to 2023. For SBUHB, the comparable figure was higher at 40% (36 stillbirths) and more variable year on year, for example in 2019, the rate was 60% and in 2022 almost 70%.

- Problems with the placenta also consistently accounted for about a third of stillbirths across the UK. Overall the rate for SBUHB was similar at 33% (30 stillbirths) with more variability year-on-year, for example 50% of stillbirths in 2020 were due to placental problems.
- For SBUHB, there has generally been a higher but reducing rate of infections as the cause of stillbirth. From 2018 to 2023, the rate for SBUHB was 9% compared to 3-4% for the UK as a whole.
- No stillbirths have been attributed to congenital abnormalities by SBUHB since 2019. UK-wide the rate of congenital abnormalities has been 8-9% over the period.
- No stillbirths were attributed to problems with the umbilical cord by SBUHB (UK-wide incidence was approximately 5% over the period).
- SBUHB rates were similar to the UK as a whole for the incidence of fetal conditions as a cause of stillbirth (such as a baby being SGA), maternal health issues and problems during labour (intrapartum events).

For **neonatal deaths**

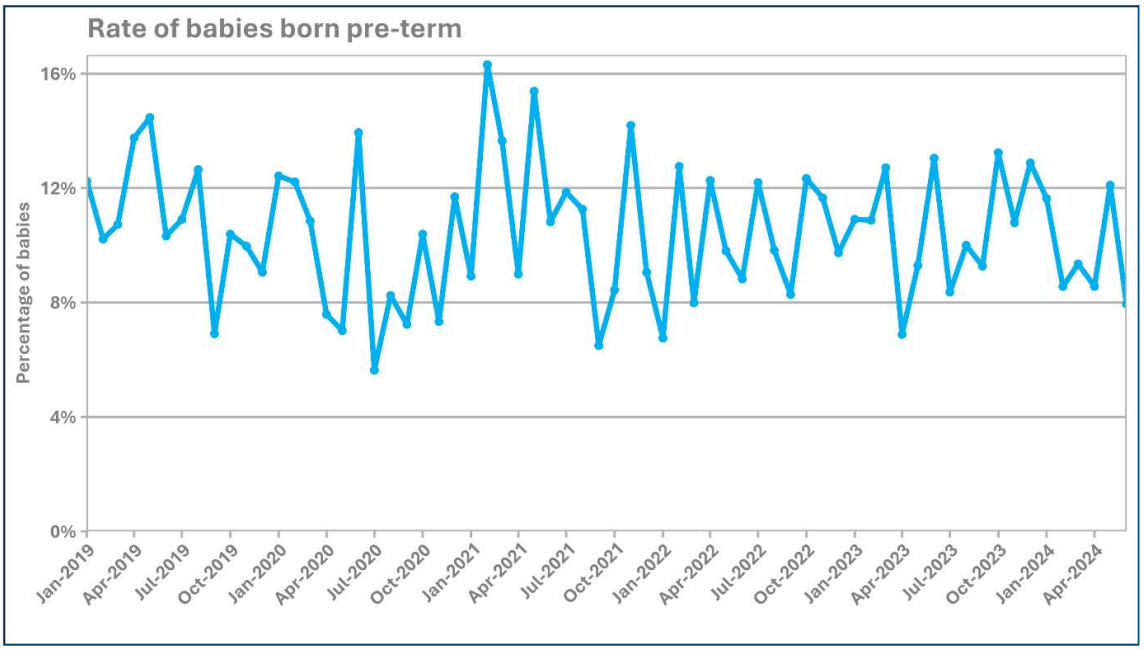
- UK-wide, the main cause of death (reported as over 40% by MBRRACE-UK over the period) was due to neonatal causes such as prematurity or low birth weight and associated health problems. For SBUHB, the number of neonatal deaths attributed to these reasons was 29, a significantly higher percentage overall of 64%.
- The next most significant cause of death reported across the UK is congenital abnormality which accounted for over a third of neonatal deaths over the period. For SBUHB, the incidence of congenital abnormality was lower overall at 18%.
- The incidence of infections as a cause of neonatal death UK-wide ranged from 6-8%. For SBUHB, the comparator rate was 13%.
- No neonatal deaths were attributed by SBUHB to complications during labour (intrapartum), for example when the baby does not receive enough oxygen. UK-wide the incidence of this as a cause of death was approximately 2%.
- No neonatal deaths were attributed by SBUHB to fetal, umbilical cord, placental or maternal health problems. UK-wide these factors accounted for between 4% and 7.5% of deaths over the period.

The MBRRACE-UK reports also capture information on the timeliness of reporting of perinatal deaths. All deaths should be notified to MBRRACE-UK within seven days of occurrence from 2020 (prior to this the requirement was within 30 days). For SBUHB, the reports show that these targets have consistently not been achieved. Over the period from 2018 to 2023, SBUHB reported:

- 43% of stillbirths and late fetal losses within the required timeframe (UK-wide 82%); in 2023 SBUHB's performance had improved to 53%; and
- 64% of neonatal deaths within the required timeframe (UK-wide over 78%); in 2023, performance had improved to 75%.

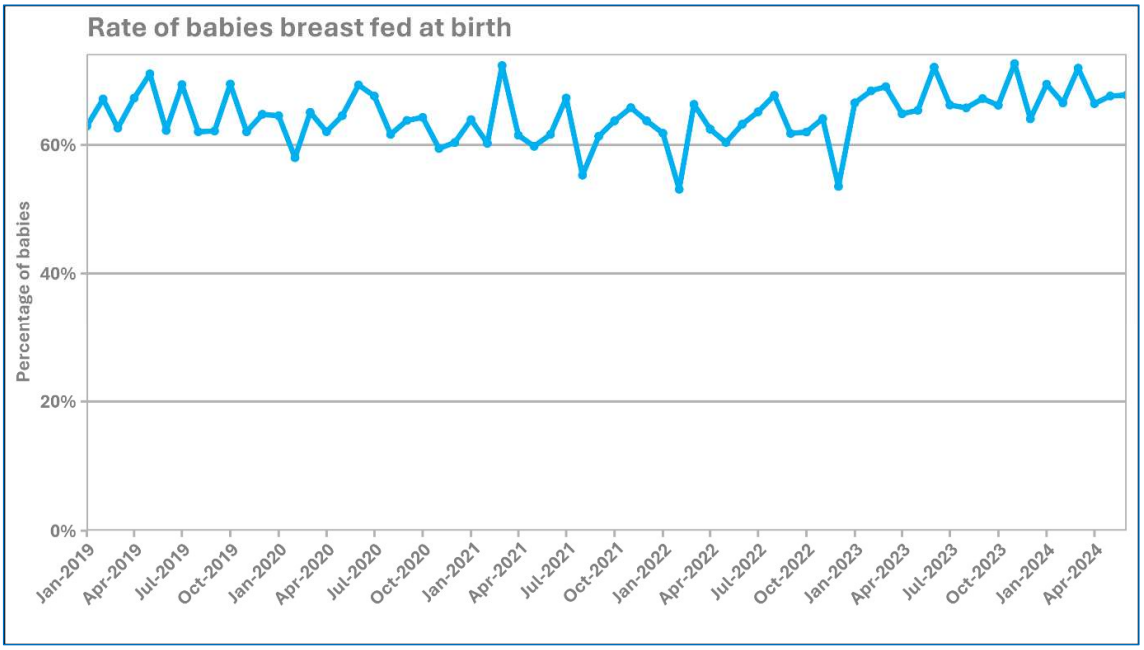
52. Rates of babies born pre-term (January 2019 to June 2024)

This metric is defined as the total number of babies born before 37 weeks of pregnancy divided by the total number of babies born. Between January 2019 and June 2024, the overall rate of babies born pre-term was **10.5%**, and this rate was stable between years with a minimum rate of **9.6%** in 2020 and a maximum of **11.2%** in 2021. In 2023, **8.1%** of births in England were preterm, compared to **10.7%** for SBUHB for the same time period.



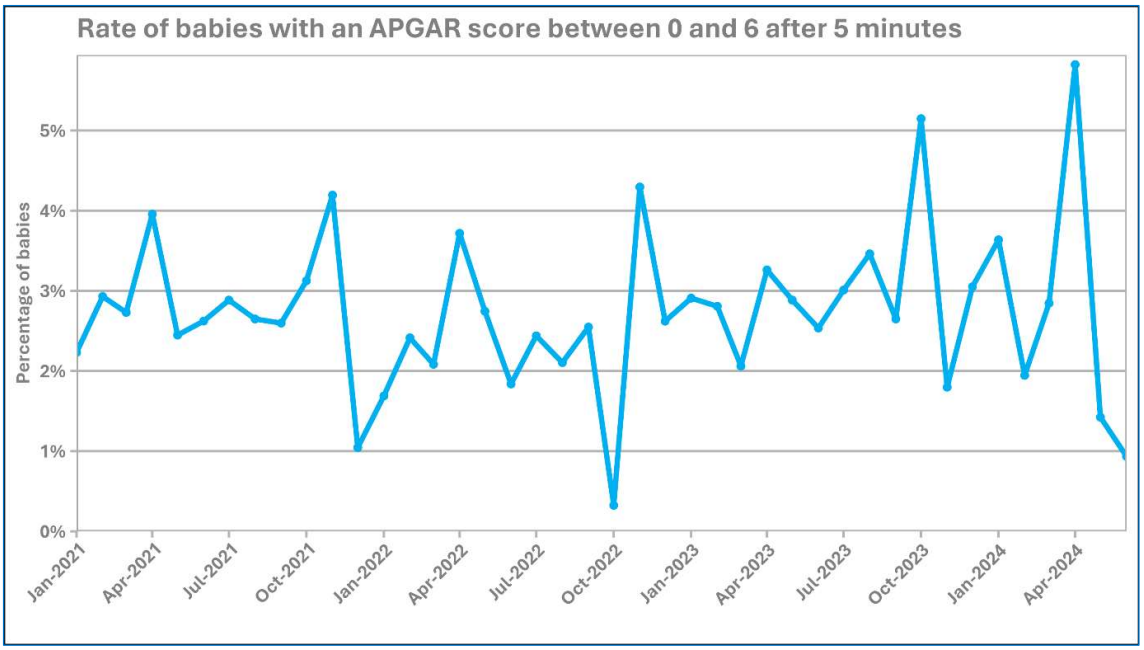
53. Rates of babies breast fed at birth (January 2019 to June 2024)

This metric is defined as the total number of babies breast fed at birth divided by the total number of babies born. Between January 2019 and June 2024, the overall rate of babies breast fed at birth was **64.6%**, and this rate appears to have increased towards the end of the period with a rate of **67.3%** in 2023 and **68.2%** in 2024.



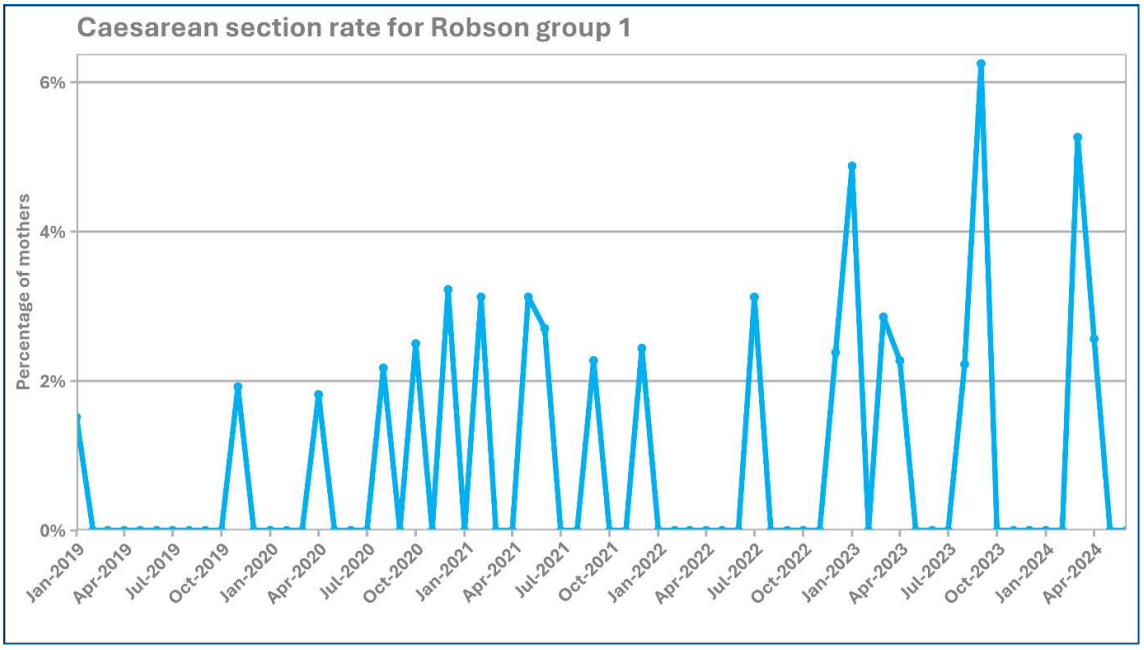
54. Rates of babies with an APGAR score between 0 and 6 at five minutes after birth (January 2019 to June 2024)

This metric is defined as the total number of babies born with an APGAR score between 0 and 6 divided by the number of births. Between January 2019 and June 2024, the overall rate of babies born with an APGAR score between 0 and 6 after 5 minutes was **2.8%**, and this rate was stable between years with a minimum rate of **2.4%** in 2022 and a maximum of **2.2%** in 2020. In 2022/23, **1.2%** of births in England reported an APGAR score of between 0 and 6, compared to **2.5%** for SBUHB for the same time period.



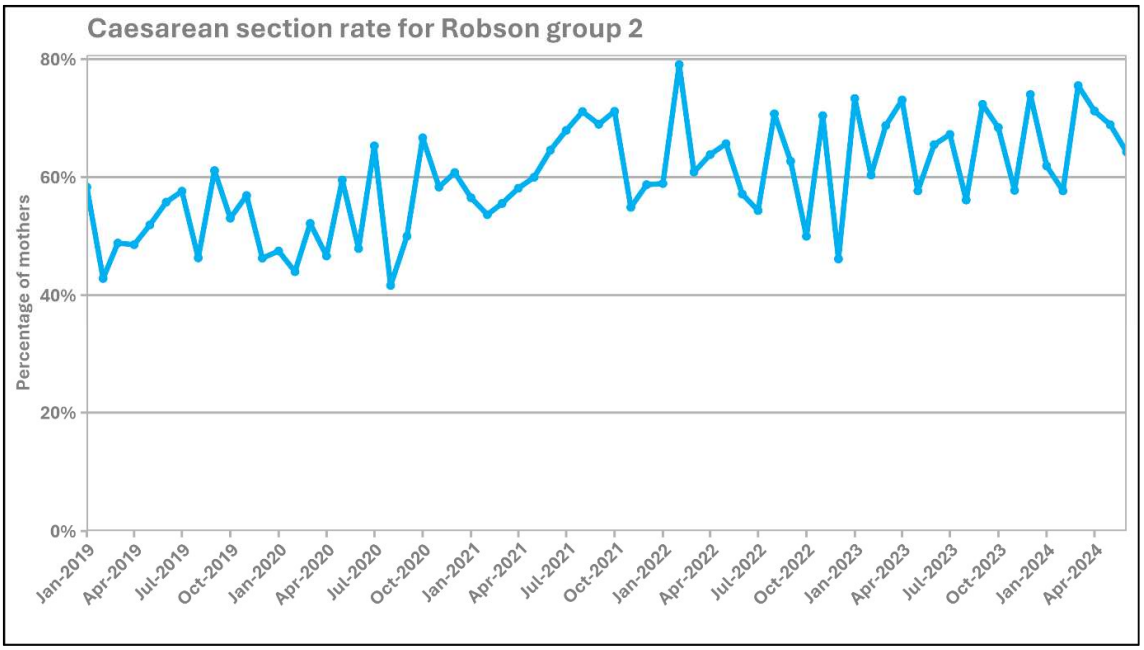
55. Rates of caesarean section in Robson Group 1 (January 2019 to June 2024)

This metric is defined as the total number of caesarean sections for women in Robson Group 1 divided by the total number of women delivering in Robson Group 1. Between January 2019 and June 2024, the overall caesarean section rate for Robson Group 1 was **0.9%**. It should be noted there are potentially data quality issues with the recording of Robson Group numbers, with many of the records incomplete.



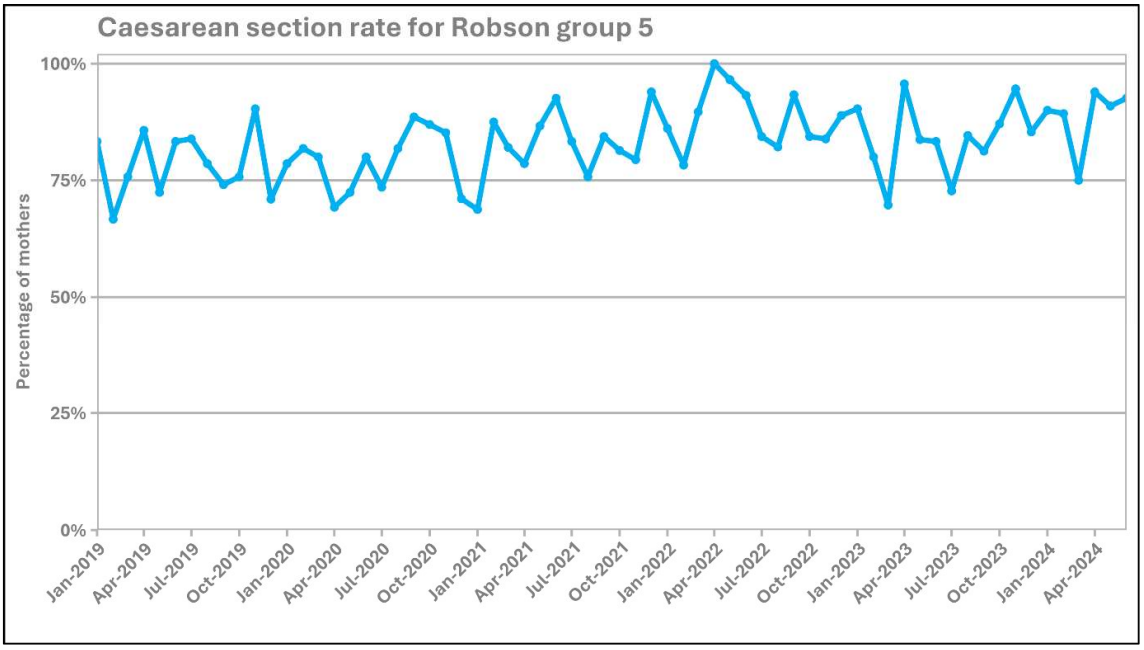
56. Rates of caesarean section in Robson Group 2 (January 2019 to June 2024)

This metric is defined as the total number of caesarean sections for women in Robson Group 2 divided by the total number of women delivering in Robson Group 2. Between January 2019 and June 2024, the overall caesarean section rate for Robson Group 2 was **60%**. It should be noted there are potentially data quality issues with the recording of Robson Group numbers, with many of the records incomplete.



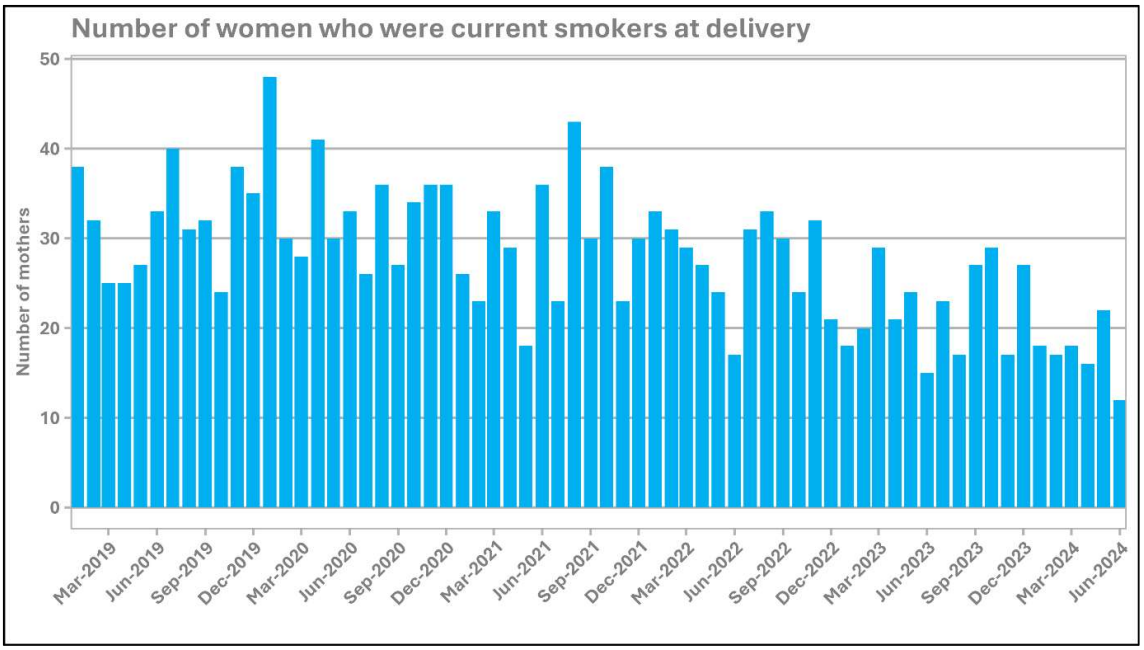
57. Rates of caesarean section in Robson Group 5 (January 2019 to June 2024)

This metric is defined as the total number of caesarean sections for women in Robson Group 5 divided by the total number of women delivering in Robson Group 5. Between January 2019 and June 2024, the overall caesarean section rate for Robson Group 5 was **83.2%**. It should be noted there are potentially data quality issues with the recording of Robson Group numbers, with many of the records incomplete.

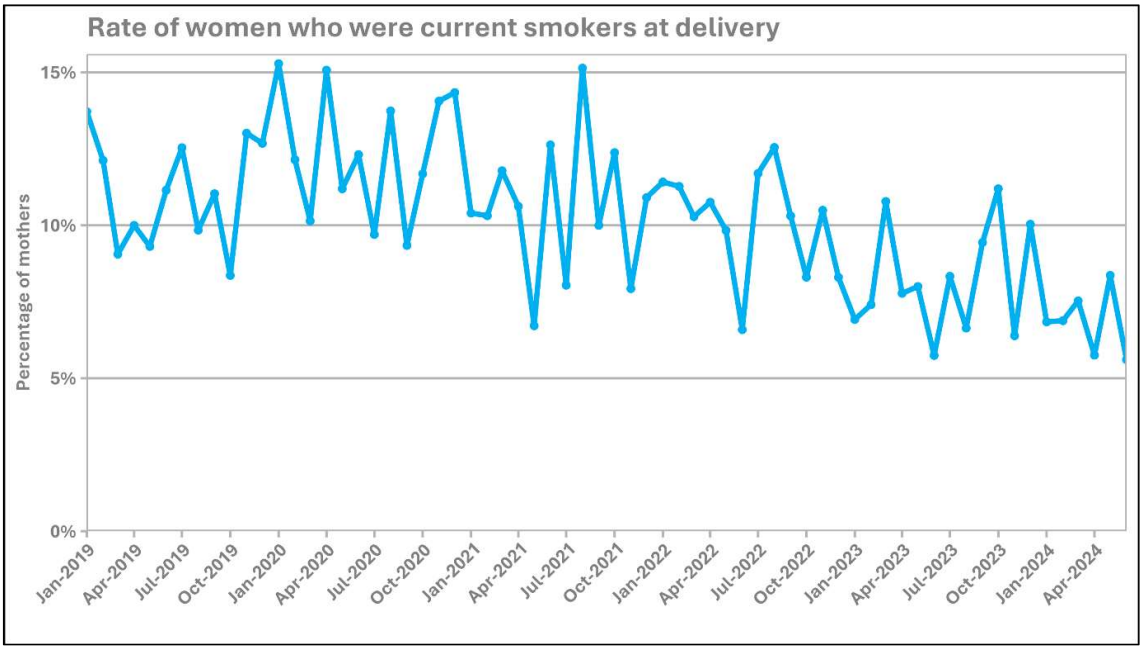


58. Smoking at the time of delivery (January 2019 to June 2024)

The average number of women who were smokers at the time of delivery between January 2019 and June 2024 was **28** per month.

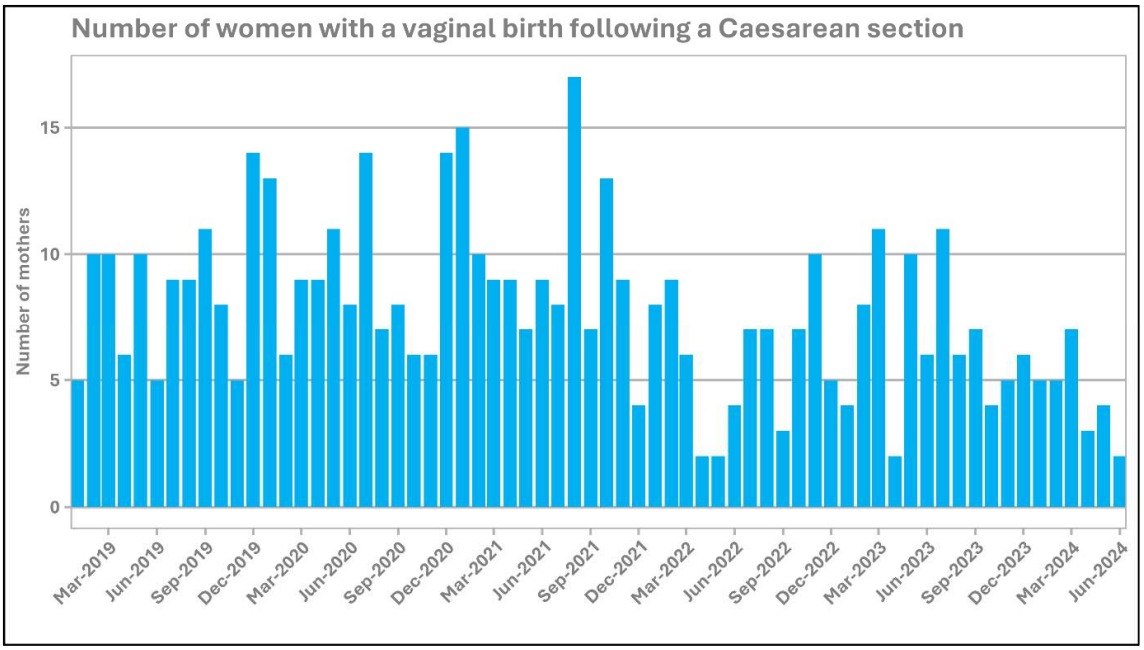


The rates of smoking at delivery are shown below. This metric is defined as the total number of women who were current smokers at the time of delivery divided by the number of women birthing. Between January 2019 and June 2024, the overall rate of being a smoker at delivery was **10.2%**, and this rate appears to have decreased towards the end of the period with a rate of **10.2%** in 2022, **8.2%** in 2023, and **6.8%** in 2024.

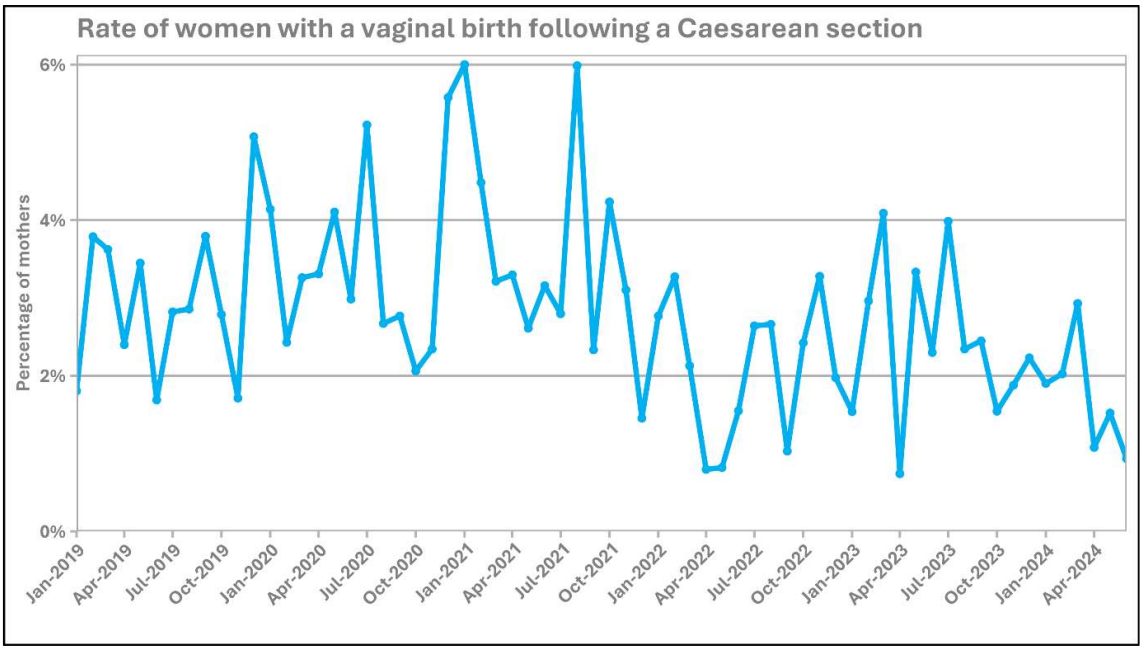


59. Vaginal birth after caesarean section (January 2019 to June 2024)

The average number of women with a vaginal birth following a caesarean section between January 2019 and June 2024 was **7.7** per month.

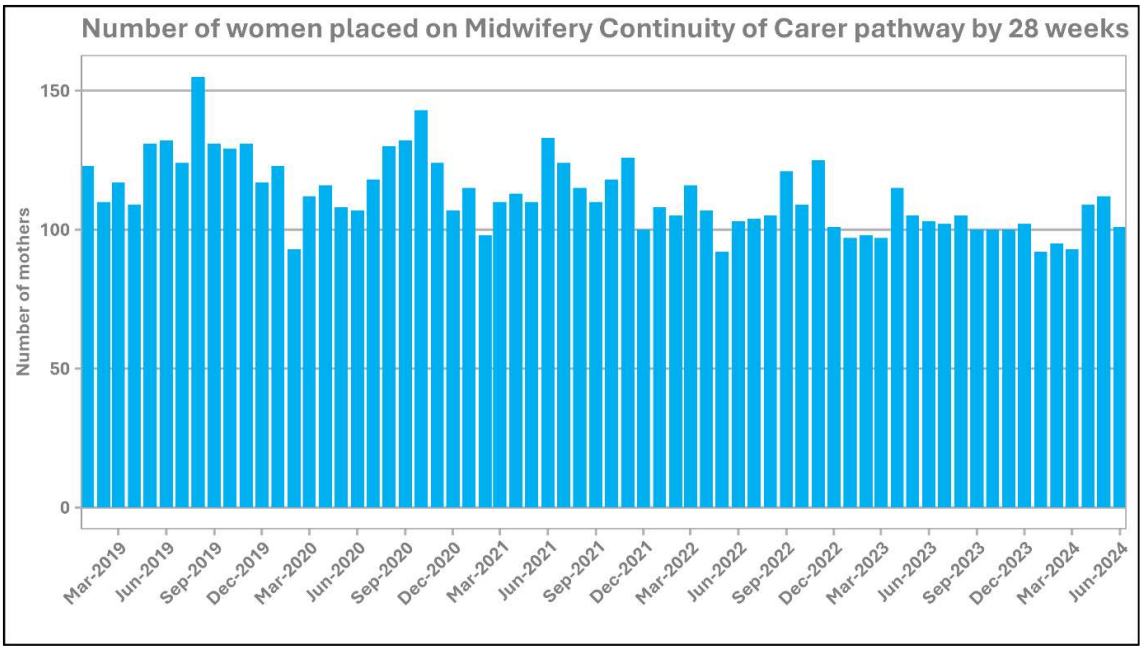


The rate of women having a vaginal birth after delivery is shown below. This metric is defined as the total number of women with a vaginal birth following a caesarean section divided by the number of women birthing. Between January 2019 and June 2024, the overall rate was **2.8%**.

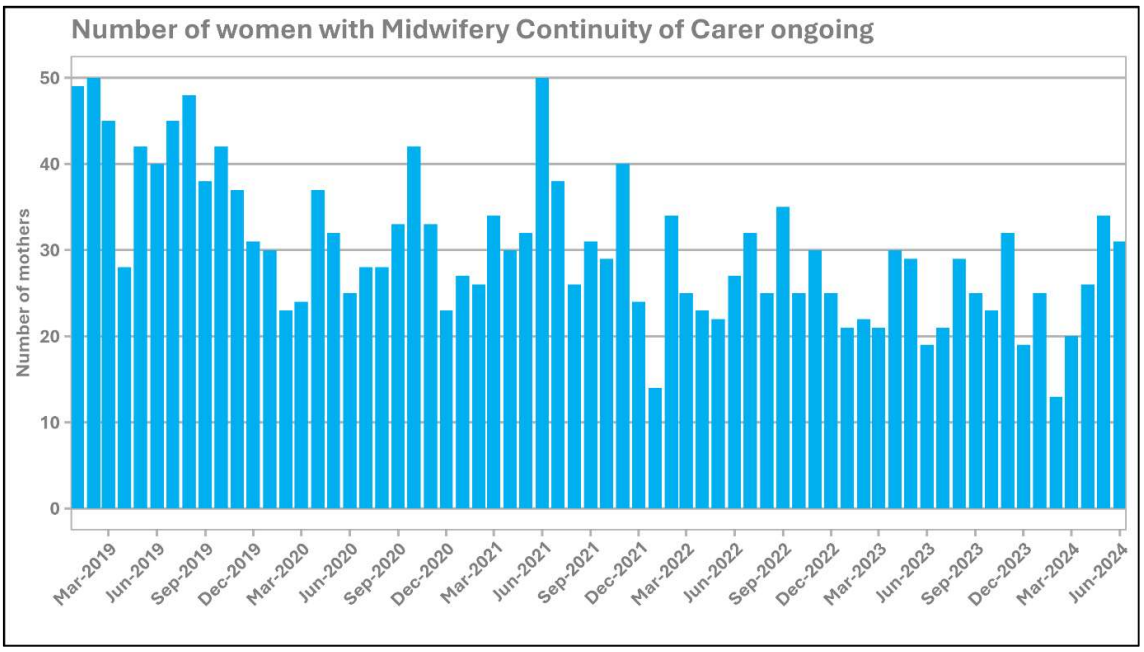


60. Midwifery continuity of care pathway by 28 weeks

The average number of women placed on a midwifery continuity of care pathway between January 2019 and June 2024 was **112** per month.

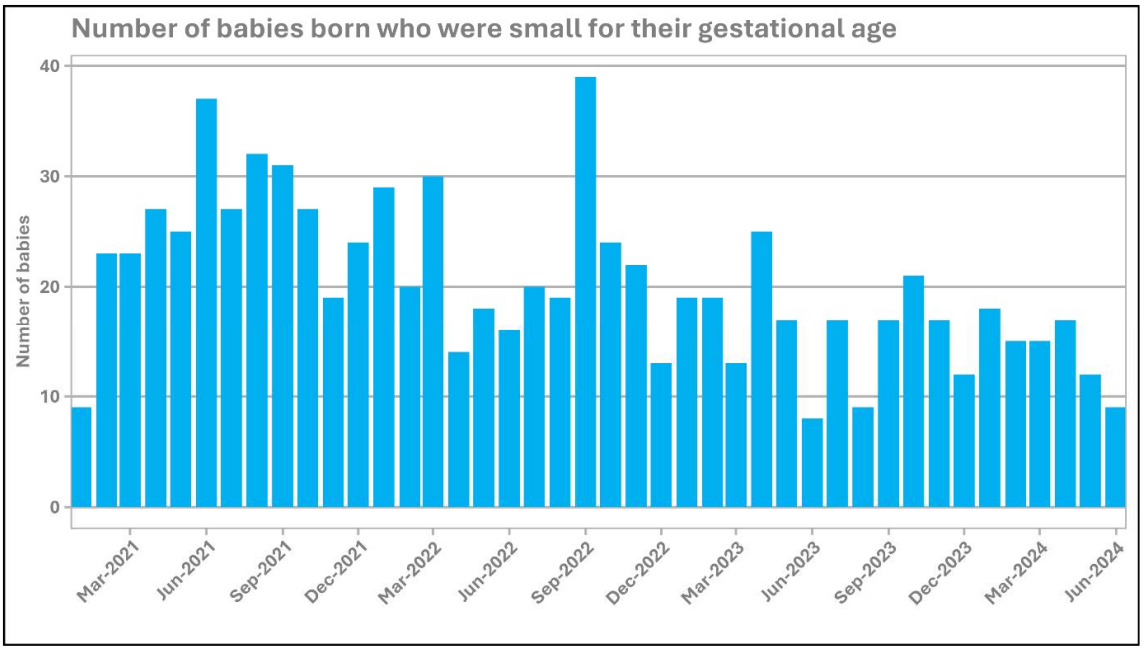


As shown below, the average number of women with Midwifery Continuity of Carer ongoing between January 2019 and June 2024 was **30** per month.

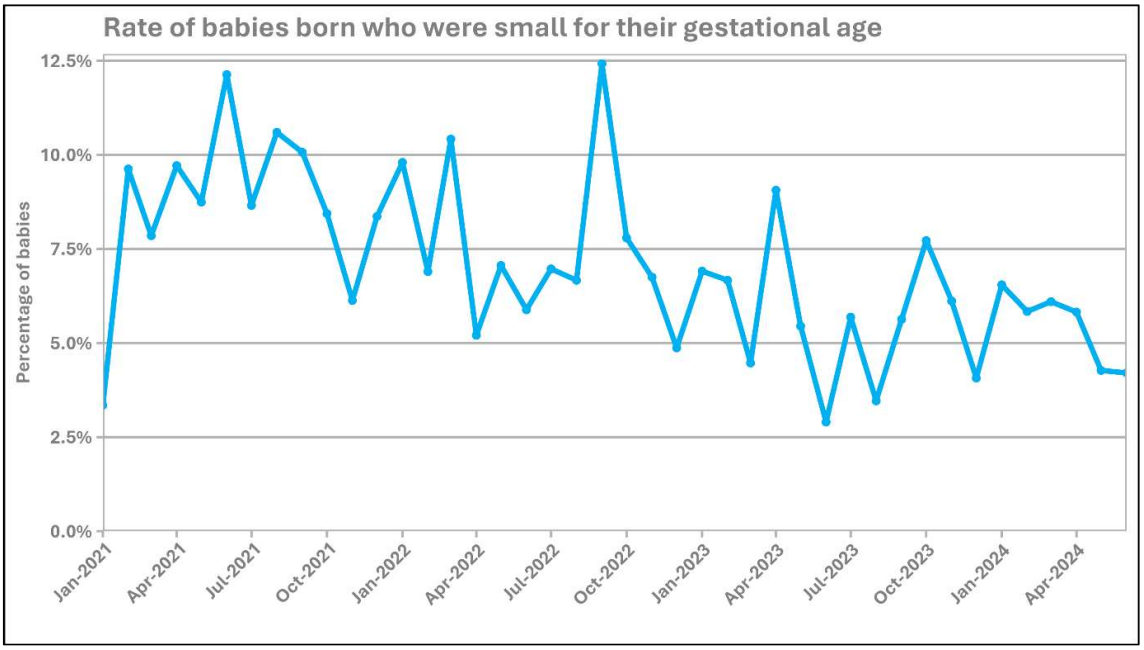


61. Babies born small for gestational age (January 2021 to June 2024)

This metric is defined as the number of babies born at, or after, 40 weeks who were less than 10th centile birth weight (i.e. weighing less than 90% of newborns of the same gestational age at birth). Between January 2021 and June 2024, the average number of babies born who were small for their gestational age was **20** per month.

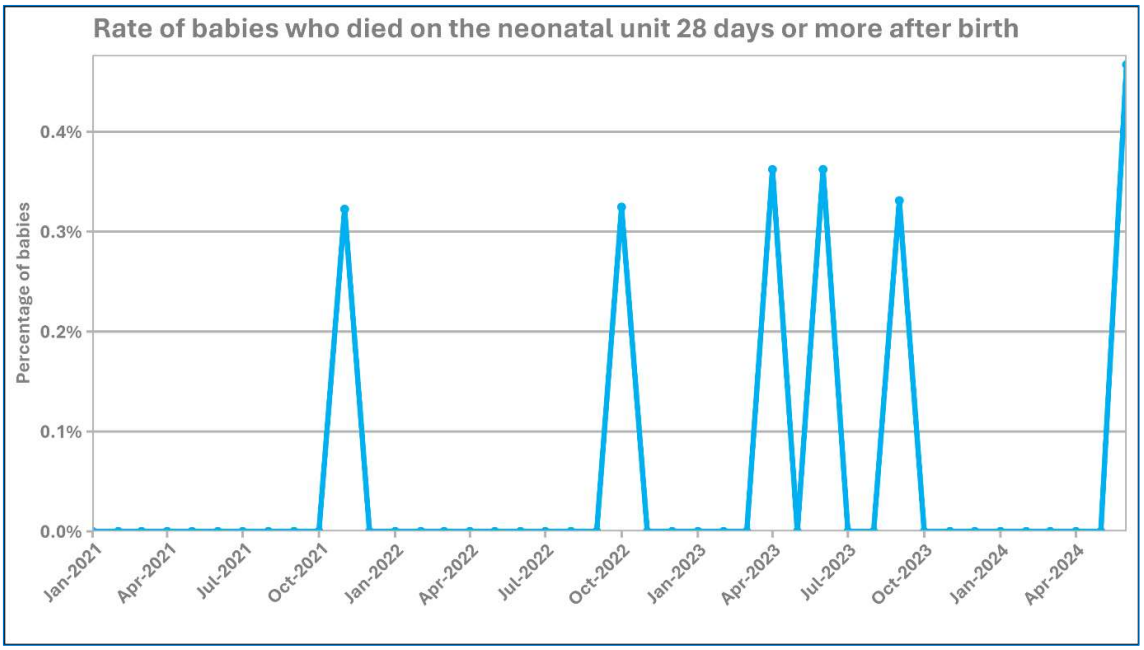


The rate of babies born small for gestational age is shown below. This metric is defined as the number of babies born at, or after, 40 weeks who were less than 10th centile birth weight divided by the total number of births. Between January 2021 and June 2024, the average rate of babies born who were small for their gestational age was **7.1%,** and this rate appears to have decreased towards the end of the period with a rate of **8.7%** in 2021, **7.6%** in 2022, **5.7%** in 2023, and **5.5%** in 2024.

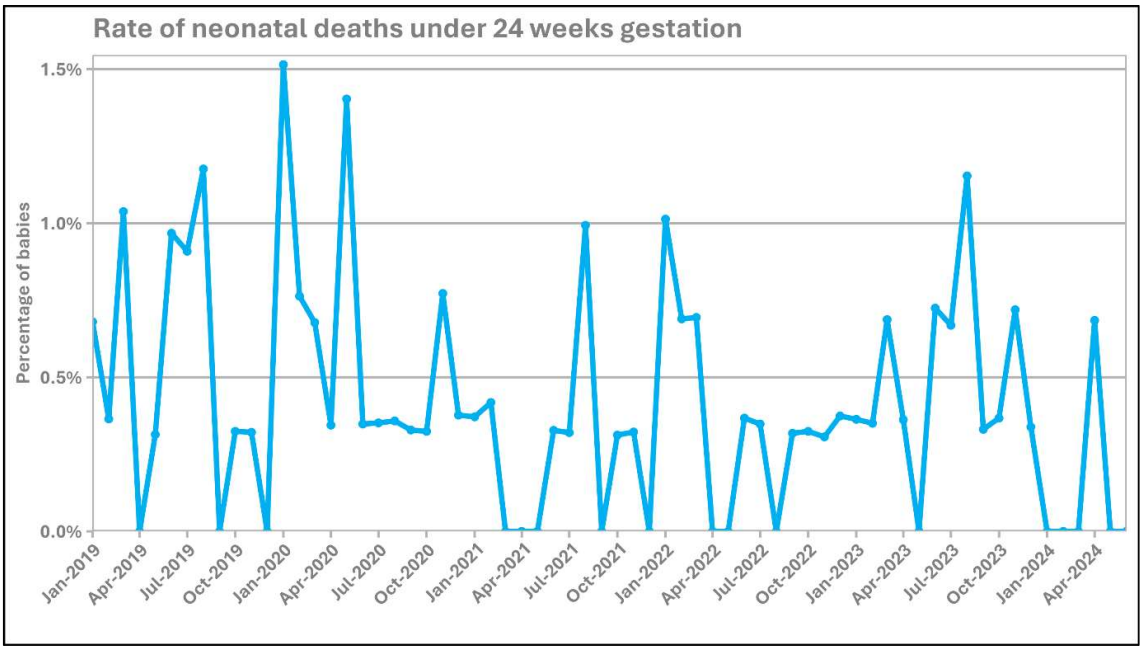


62. Babies who died on the neonatal unit 28 days or more after birth (January 2019 to June 2024)

The overall rate of babies who died on the neonatal unit 28 days or more after birth between January 2019 and June 2024 (as a percentage of births) was **0.05%**.



The overall rate of neonatal deaths of babies under 24 weeks gestation between January 2019 and June 2024 (as a percentage of births) was **0.43%**.



E. Staffing data

Data was received from the Health Board's Birthrate+ staffing and workload tool, a workforce planning and decision-making framework which allows staff to assess whether staffing levels at a particular time meet the clinical needs of women and babies on the Labour Ward.

Staff enter data on the number of midwives (including co-ordinators) and the total number of women on the Labour Ward at 4-hourly intervals (9AM, 1PM, 5PM, 9PM, 1AM and 5AM), and the tool calculates the total acuity level on the ward (based on a weighted score reflecting the complexity of each case), and provides an assessment of whether the level of staffing meets the level of acuity on the ward.

Extracts of data from the staffing tool were provided for each week between January 2019 and July 2024.

63. Completeness of Birthrate+ data submissions (January 2019 to June 2024)

To ensure confidence when reviewing the data submitted to the tool, Birthrate+ recommend data should be recorded on at least 85% of all possible occasions. Data is submitted 6 times a day at 4-hourly intervals which means there should be at least 36 occasions when data is submitted to the tool in a particular week (out of a possible 42). The table below shows the overall results for SBUHB.

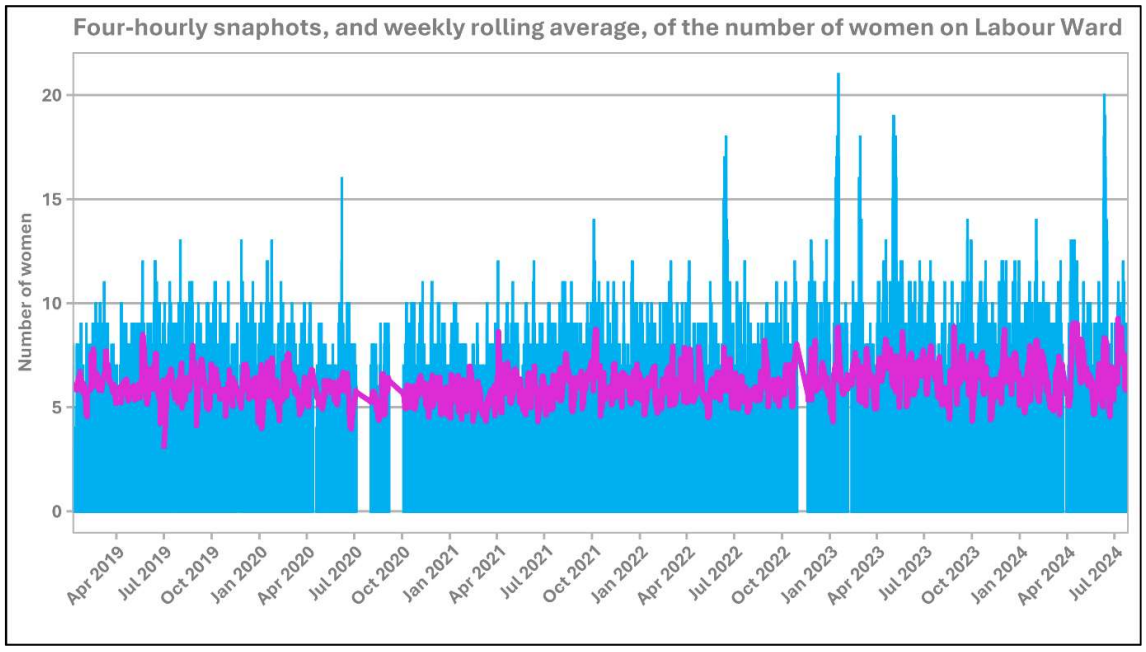
Year	Number of weeks data submitted	Number of weeks with adequate data recorded*	Weeks of missing data	% of weeks with adequate data recorded
2019	52	37	0	71.0%
2020	44	35	8	67.0%
2021	52	44	0	85.0%
2022	52	44	0	85.0%
2023	53	45	0	85.0%
2024	28	26	0	93.0%
Total	**281**	**231**	**8**	**80.0%**

* Defined as data being recorded on at least 36 out of 42 occasions for a particular week

With the exception of 2020, data has been submitted for every week in the year between January 2019 and July 2024, and the completeness of recording has improved over time. From January 2021 onwards, at least 85% of all weekly data files submitted have data recorded for at least 85% of all time intervals.

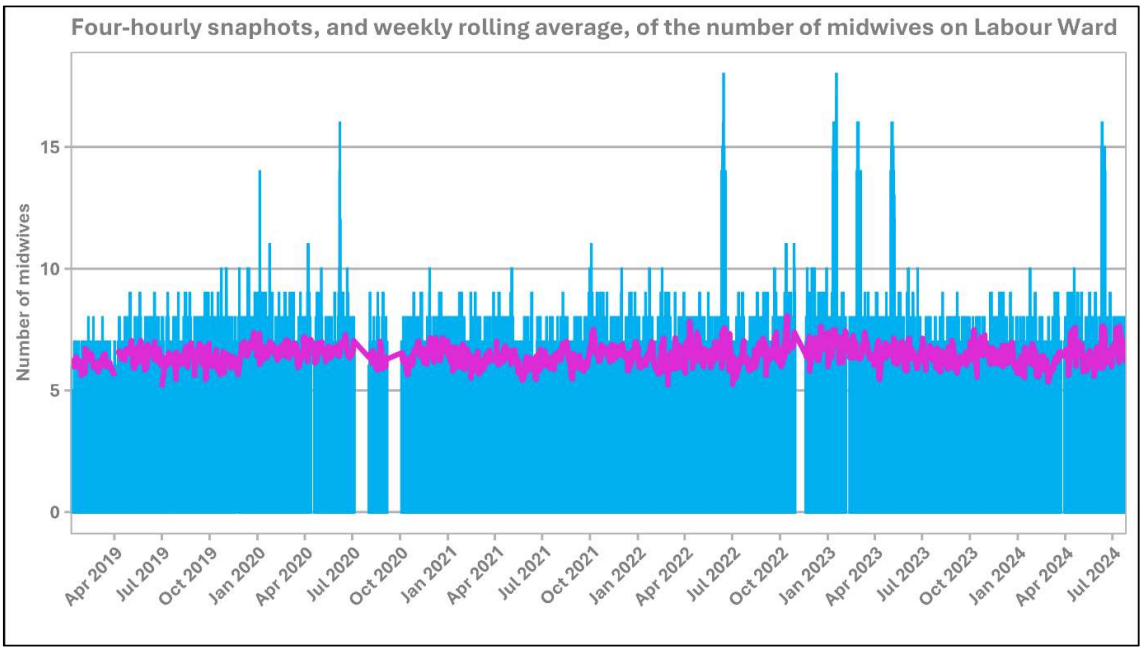
64. Birthrate+ four-hourly snapshots of the number of women on Labour Ward (January 2019 to July 2024)

On average, across all the 4-hourly snap shots in the data period, there were an average of **6.1** women on the Labour Ward at any given point, with a maximum of **14** women. The average varied by year with recent years recording higher averages: in 2019 the average was **6.0** women, **5.7** in 2020, **5.9** in 2021, **6.1** in 2022, **6.5** in 2023 and **6.5** in 2024 (January to July).



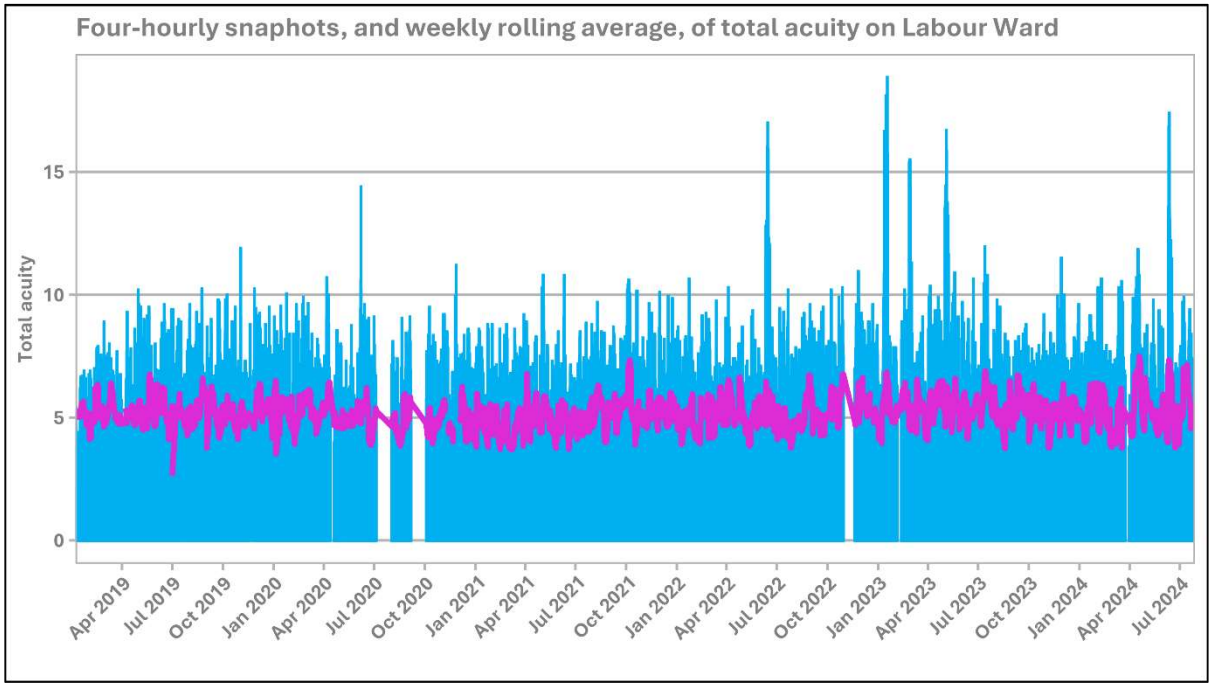
65. Birthrate+ four-hourly snapshots of the number of midwives on Labour Ward based (January 2019 to July 2024)

On average, across all the 4-hourly snap shots in the data period, there were an average of **6.4** midwives on the Labour Ward at any given point, with a minimum of **3** and a maximum of **11** midwives recorded at any point. The averages were relatively constant across years with **6.3** in 2019, **6.6**.in 2020, **6.3** in 2021, **6.5** in 2022 and 2023, and **6.4** in 2024. See chart below.



66. Birthrate+ four-hourly snapshots of acuity on Labour Ward (January 2019 to July 2024)

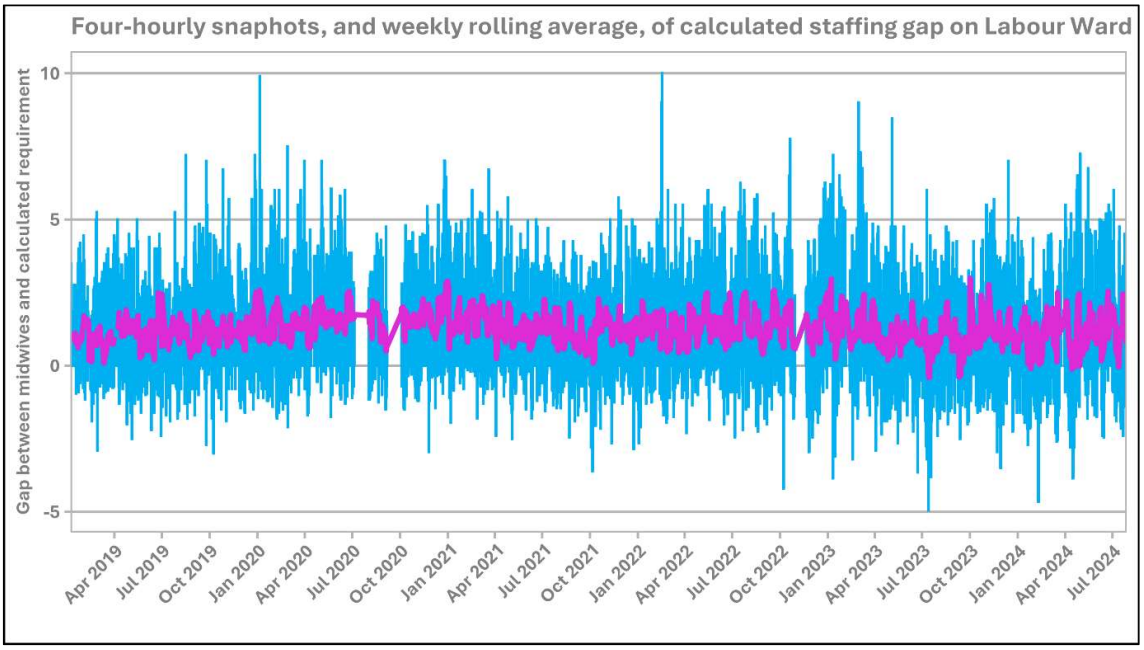
Across all the 4-hourly snap shots in the data period the average total acuity present on the ward was **5.2** and this was relatively stable across years. In 2019 the average acuity score recorded across all points was **5.2**, **5.0** in 2021, **5.0** in 2021, 5.2 in 2022, **5.4** in 2023 and **5.3** in 2024 January to July).



67. Birthrate+ four-hourly snapshots of gap between actual and recommended staff on Labour Ward (January 2019 to July 2024)

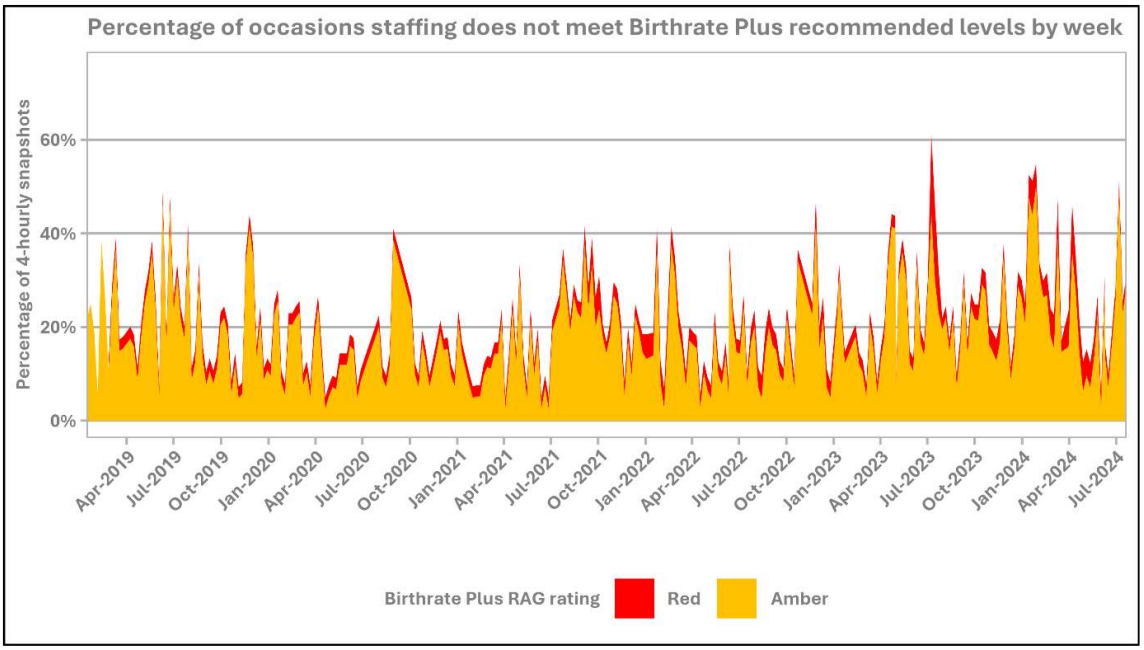
The chart below shows the average gap between the actual number of midwives, and those recommended by the tool based on acuity on the ward (with a negative number indicating the actual number was less than the recommended number). Across the analysis period the average gap was **1.3** indicating that, in general, the number of midwives was sufficient for the recorded acuity.

On **18%** of occasions, however, staffing did not meet the acuity. This percentage also varied by year, with **20%** in 2019, **13%** in 2020, **17%** in 2021, **16%** in 2022, **21%** in 2021, and, so far, between January and July 2024 staffing has not matched acuity on **25%** of occasions.



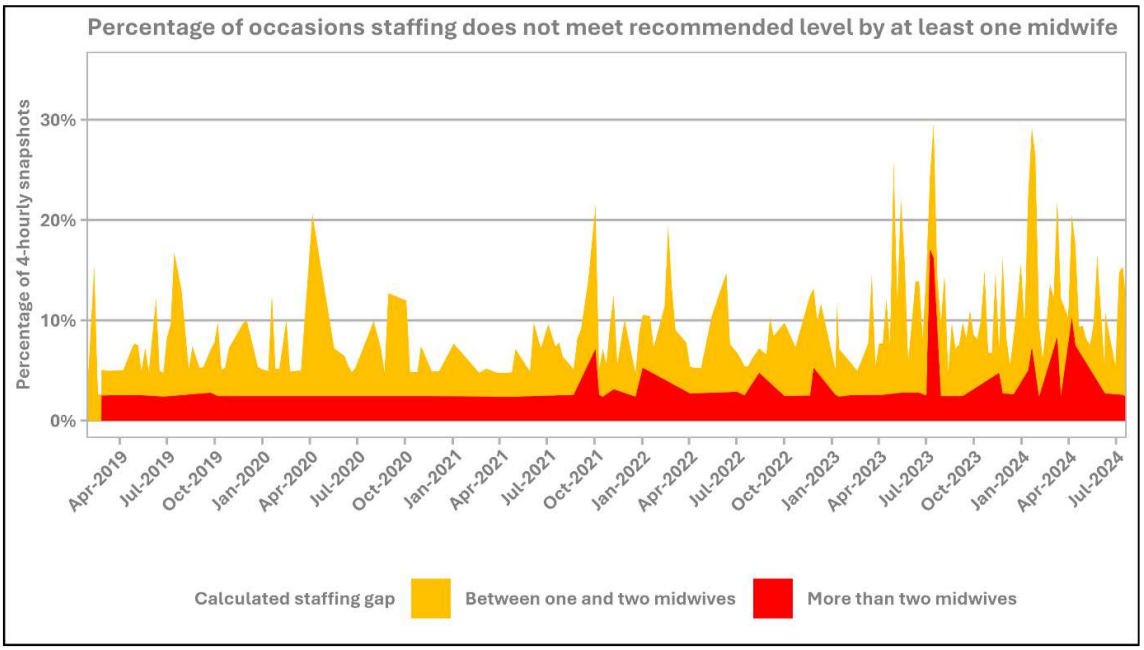
68. Percentage of four-hourly snapshots on Labour Ward where staffing does not meet recommended Birthrate Plus levels for acuity level (January 2019 to July 2024)

Birthrate+ uses a RAG rating, with any occasions the gap between the actual number of midwives and the number recommended based on acuity is between 0 and -2 labelled amber, and gaps larger than -2 labelled red. The chart below shows, by week, the proportion of observations recorded as red or amber. Over the whole data period the percentage flagged as red or amber was **18%**, although this varied by year, with **20%** in 2019, **13%** in 2020, **16%** in 2021, **16%** in 2022, **21%** in 2023, and **25%** in 2024 so far (January to July).



69. Percentage of four-hourly snapshots on Labour Ward where staffing does not meet recommended Birthrate+ levels for acuity level, with a gap of 1 midwife or more (January 2019 to July 2024)

The chart below repeats the previous analysis showing where the gap between the actual and recommended number of midwives is greater than 1. Over the data period the percentage of occasions flagged as having a gap of 1 midwife or more was **4.7%**, with a deterioration more recently (**7.5%** in 2023, and **9.2%** in 2024 (January to July).



70. Distribution of acuity levels of women recorded on Labour Ward (Birthrate+ classifications) by year (January 2019 to July 2024)

The table below shows the distribution of the recorded Birthrate+ categories across all 4-hourly points between January 2024 and July 2024. This is not a breakdown of individual women on the ward (as a woman could be counted more than once across the 4-hour intervals) but will give a good indication of the levels of acuity on the ward. The most frequently recorded category was Acuity IV.

Proportion of women recorded in Labour Ward						
Recorded Birthrate+ Category	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Acuity I	0%	0%	0%	0%	0%	0%
Acuity II	0%	0%	0%	0%	0%	0%
Acuity III	13%	12%	9%	6%	5%	6%
Acuity IV	25%	29%	26%	27%	26%	24%
Acuity V	4%	5%	6%	6%	6%	5%
Acuity A1	9%	7%	10%	11%	9%	9%
Acuity A2	5%	7%	9%	8%	8%	8%
Acuity PD1	8%	6%	6%	6%	7%	6%
Acuity PD2	22%	17%	18%	21%	21%	23%
Acuity PN	13%	17%	17%	14%	18%	18%