GWASANAETHAU MAMOLAETH A NEWYDDENEDIGOL
Adolygiad Annibynnol o Fae Abertawe

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

MATERNITY AND NEONATAL SERVICES
Independent Review of Swansea Bay

July 2025

Contents

Report Advisory Notice

This is a summary report the findings of which are taken from the Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board. Only the full version of the report should be seen as the definitive assessment of maternity and neonatal services.

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

Foreword by the Chair of the Independent Review,

Dr Denise Chaffer, CBE.

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

This report has three key components: the voices of families sharing their experiences; a clinical review of cases undertaken by experienced, independent, clinical team; and a wider governance and leadership review of the Health Board's processes.

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

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

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

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

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

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

The review of governance in relation to maternity and neonatal services, has identified significant weaknesses in the period between 2021 and 2024, which includes the need for immediate review of the Health Board's complaints processes, improvements to board reporting and oversight, investigation, risk management and governance processes.

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

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

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

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

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

The work of this review does not and must not stop here. The Health Board must ensure this conversation continues until all changes are made, and sustained improvements are demonstrated for the women and families that the Health Board serves."

Dr Denise Chaffer, CBE.

Chair of the Independent Review, July 2025.

Foreword by Sarah Land,

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

Thinking of the families

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

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

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

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

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

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

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

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

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

Sarah Land

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

1. Summary of report

Introduction

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

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

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

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

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

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

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

- Over the period from 2018 to 2023, 90 stillbirths were reported to MBRRACE-UK, with peaks of 20 in 2020 (this was the Covid-19 pandemic year) and 16 in 2023. Over the same timeframe, 45 neonatal deaths (a live born baby who died up to 28 days after birth) were reported with peaks of 12 in 2021and 9 in 2023. For context, the number of deliveries over the five-year period was almost 17,000.
- The stillbirth rate increased from 2018 to 2020; SBUHB was highlighted as an outlier in 2020 (the Health Board's adjusted mortality rate was more than 5% higher than the average of similar Trusts and Health Boards). However, from 2021 to 2023, the stillbirth rate decreased and was comparable to other peer group organisations.
- SBUHB was an outlier on neonatal mortality rates in 2019, 2021 and 2023 (the Health Board's adjusted mortality rate was more than 5% higher than similar Trusts and Health Boards).
- When viewed together for stillbirths and neonatal deaths, SBUHB was an outlier for three consecutive years between 2019 and 2021, and then also in 2023. In 2018 and 2022, the Health Board's rates were similar to, or lower than, the average for comparator organisations.

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

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

1.7 This review has worked with the core ambition of ensuring that the **safety system** surrounding maternity and neonatal services can be optimised, as opposed to seeking individual blame. 'Systems thinking' is known to promote lasting and reliable change and to ensure the safety of services into the future.

The experiences of women and families

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

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

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

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

1.12 In analysing the information, quotes and experiences in this way, seven key themes emerged:

Some of the comments across the key themes included:

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

1.2 "I did not know who my named midwife was until I was 38 weeks pregnant".

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

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

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

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

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

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

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

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

1.11 “When I said no to the midwife, she was shocked, but I had done some research and knew that this wouldn’t help me.”

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

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

1.14 “Why is it such a struggle to get mental health support. When I asked for it I was told that because I wasn’t suicidal, I could not have it. Even the bereavement midwife asked for it and was told no. I get flashbacks of the first pregnancy. I do not want to be treated by the midwife that was in the assessment unit as I am sure this will give me further flashbacks, and I could not stand it.”

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

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

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

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

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

Llais report of May 2025

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

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

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

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

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

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

Clinical findings from detailed case reviews

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

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

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

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

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

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

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

Staffing and leadership

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

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

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

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

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

Governance

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

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

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

1.41 Complaints handling has historically been poor. A significant backlog of complaints had developed which has impacted overall response times. The quality of complaint responses lacked compassion, and this is still an issue.

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

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

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

1.44 Further work is still needed on:

- strengthening ward-to-Board assurance and reporting and Board-to-ward oversight, to ensure maternity and neonatal services receive sufficient profile; and
- redesigning service-level governance structures to reflect collaborative and interdependent team approaches between maternity and neonatal services.
- we found that the interface between the Maternity and Neonatal Clinical Network and the Health Board requires improvement. We found that the Health Board was unable to access some insights (for example, mortality information) because this was held on the national, shared Datix system. In addition, some risks that maternity and neonatal services are carrying cannot be mitigated or influenced by the Health Board alone.

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

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

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

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

Can women and families have confidence in these services today?

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

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

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

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

Safety for mother and baby

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

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

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

What do the latest outcomes and developments suggest?

1.54 Antenatal computerised cardiotocography (CTG) monitoring is now a widely used tool for fetal assessment in the antenatal period within the UK and can be very important in the detection of issues which may lead to problems at birth. Most local guidelines recommend its use for all babies requiring a CTG in the antenatal period. However, antepartum CTG interpretation by staff has been identified as a significant root cause of stillbirth and serious brain injury (BMJ, 1994).

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

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

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

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

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

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

Accessing services when you need them.

1.61 The Health Board has made improvements in the way that people can access services and the choices that they have about the kind of birth that they want. For example, the home birth

service was restarted in October 2024 and the midwifery-led birth centre at Neath Port Talbot Hospital was also re-opened in September 2024. Services being located on different sites is a risk which requires increased attention by the Health Board.

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

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

1.64 If labour needs to be induced, then there are some risks that this may be paused or stopped or restarted. The Health Board are trying hard to minimise this because they know that it is stressful for women. More information about induction is being developed and the Health Board is contributing to All Wales approaches around this. Induction rates have remained relatively stable over the last four years and are falling below the national average.

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

Access to pain relief

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

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

Kindness and compassion

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

- The new Swansea Bay Maternity Services Charter openly commits to how the Health Board will treat people with compassion and care.
- Access to the debrief process has increased with the recruitment of a dedicated midwife in this area and in addition, debriefs are now working more with families' timescales rather than the service's timescales.

- All nurses and midwives will receive specialist bereavement training. We also suggest that the same cohort of staff, plus staff working in complaints, should receive specialist training in trauma.
- All families who have experienced a stillbirth or neonatal death will be invited to contribute to and receive a written account of the mortality review process and will be advised of the timelines for the final review report. There will also now be a named contact from the governance team, along with details of how to contact the team, should they have any questions regarding their review.
- Response times for complaints are reducing although more work needs to be done in terms of the compassion shown in these responses.
- A Maternity Services Patient Experience Forum has been established. The Maternity Voices Partnership (MVP) is also planning neonatal and postnatal '15 steps'[2] visits.
- There is a plan to recruit a full-time Women's Experience Midwife. Since April 2025, the Health Board has started issuing surveys to all people using maternity services throughout their pregnancy and following birth.
- A 'Dads and birthing partners survey' is also now running to enable the MVP to gain insights around these experiences.

Access to information and support

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

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

- Increasing support for breastfeeding with continuation of training for staff to Baby Friendly Initiative[3] standards, increased midwifery resource for this purpose and the introduction of additional support groups.
- Having enough staff on shifts and making sure that sickness and absence are covered will release staff time to support women, focussing on ensuring a woman is always placed at the centre of her care.
- The MVP is developing an 'Ask Us' campaign/strategy, so the slogan 'Ask Us' would be visible across all of maternity services.
- Ensuring that women are involved in decisions about their care needs to run throughout all aspects of maternity and neonatal services. This requires a cultural shift and awareness, more access to information, more access to choice and a focus from staff on informed consent.

1.70 Women feel more vulnerable when they cannot make an informed choice[4], even in urgent situations. Risks must be properly explained to women and their families and there must be recognition that women may need to have several conversations, or they may need information which is delivered in a different way.

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

Recommendations

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

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

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

2) Delivery of consistent care with senior clinical staff oversight

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

3) Implementation of Maternity Early Warning Scores (MEWS)

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

4) Improve quality of Investigations

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

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

5) Delivery of compassionate and trauma-informed care

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

6) Improvements in governance processes

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

7) Attendance for all maternity staff for fetal monitoring training

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

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

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

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

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

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

Audit of recommendations

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

Additional recommendations for consideration by the Welsh Government:

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

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

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

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

Next steps

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

- The self-referral website will now transfer to the Health Board from the Niche hosting-site.
- The review triage midwife will remain in her support role over the next few months.
- More recently families have been supported to meet with very senior leaders within the Health Board so that they are able to provide a first-hand account of their experiences.
- The psychological support put in place through the course of this review, will remain open for the foreseeable future.

1.73 The Terms of Reference state that following completion of the Review, the Oversight Panel will continue to oversee the implementation of any recommendations against key milestones.

1.74 Therefore, after publication of the report, the Oversight Panel's focus will turn to:

- supporting the engagement of service users and key stakeholders to facilitate a partnership / collaborative approach with the Health Board in developing the improvement plan;
- quality assuring the improvement plan produced in response to the recommendations to ensure the actions will timely address the recommendations; and
- undertake a periodic review, at six monthly intervals, against key milestones and reporting the Board of the Health Board.

1.75 In September 2026, the Oversight Panel will consider the progress made against the milestones and whether, at that point, the Oversight Panel will formally end their input to the Health Board.

1.76 The Oversight Panel are pleased to submit this review to support further learning across Wales and across England. The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board would be particularly happy to support the development of standardised Terms of Reference for maternity reviews which consider to full and extensive volume of facts relating to the performance of maternity and neonatal services.

Final acknowledgements

We would like to thank all participating families, communities, staff, stakeholders and the Health Board for their positive contributions to this review. We hope that the extensive work detailed in these pages is helpful towards the continued improvements in maternity and neonatal services at Swansea Bay University Health Board and across Wales.

End notes

[1] Having a baby in Neath Port Talbot and Swansea. Experiences of maternity and neonatal services in Swansea Bay University Health Board https://www.llaiswales.org/sites/default/files/2025-05/Experiences%20of%20maternity%20and%20neonatal%20services%20in%20Swansea%20Bay%20University%20Health%20Board_0.pdf

[2] https://www.england.nhs.uk/publication/the-fifteen-steps-challenge-quality-from-a-patients-perspective-an-inpatient-toolkit/

[3] https://www.unicef.org.uk/babyfriendly/accreditation/

[4] https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making