Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 October 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	National Maternity and Neonatal Services Assessment
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mrs Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Ms Cerian Llewelyn, Interim Director of Midwifery

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides assurance on progress and next steps in response to internal benchmarking that has taken place in response to an All- Wales assurance assessment of maternity and neonatal services based on the preliminary data available. The assessment is due to commence on the 20th October 2025.

Cefndir / Background

Earlier this year Jeremy Miles MS, Cabinet Secretary for Health and Care announced commissioned an all-Wales assurance assessment of maternity and neonatal services to assess the safety and quality of services in light of the findings from the Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board

This nationally commissioned assurance assessment is part of a suite of interventions which the Welsh Government is committed to ensure that the maternity and neonatal safety support programme remains contemporary and responsive to changing evidence for improved outcomes. It will focus on assessing maternity and neonatal services across Wales against the criteria within the National Quality Statement and Quality Standards. It will identify areas of good practice and those where there may be residual risk or concern within maternity and neonatal care.

The assessment will be multi-faceted and aims to provide independent assurance on the quality and safety of maternity and neonatal services across Wales, drawing on learning from recent reviews across the UK, including in Swansea Bay. The work will be led by NHS Wales Performance & Improvement and supported by an independent Chair and an Oversight Board.

Though the Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board identified a number of key recommendations, this report is not in isolation. A number pf major reports into maternity care in England, Northern Ireland and Wales in the last five years have included:

- Review of Maternity Services at Cwm Taf Morgannwg Health Board (Panel, 2022)

- Independent Review of Maternity Care at The Shrewsbury and Telford Hospitals (Ockenden, 2022)
- Maternity and Neonatal services at East Kent (Kirkup, 2023)
- Enabling Safe Quality Midwifery Services and Care in Northern Ireland (Renfrew, 2024)
- The UK Birth Trauma Report to Parliament (2024)

All reports have provided an extensive number of recommendations arising from a range of different themes which are broadly consistent across reviews and unfortunately have identified a number of key themes:

- Women frequently feel discounted in their care
- Families can be harmed by poor care which lacks compassion. Not only can the harms caused by poor care be life-changing for the family and the child, but the emotional impacts on both the mother and birth partner can frequently become a disease burden in themselves.
- The risk profile of women giving birth is increasing in some areas. Women can give birth later, lifestyle factors may create ill health, and women may present to maternity services at a later stage when they are in subsequent pregnancies
- Staff are not always able to deliver the care that they are trained for and want to provide, and safe staffing is cited as an issue in almost all reviews.
- Monitoring, escalation and rapid intervention are not where they should be. Boards are often not sufficiently aware of issues in maternity, and staff on wards are not getting sufficient access to the information that they need to provide them with insight on how their services are performing.
- There is insufficient scrutiny applied when things go wrong. Investigations are of poor quality, women and families do not get the early and compassionate answers they seek, organisations can easily look evasive, and the whole system fails to learn and improve

The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board identified 10 priority recommendations

- Establish a single point of access for maternity triage for all women
- Delivery of consistent care with senior clinical staff oversight
- Implementation of Maternity Early Warning Scores (MEWS)
- Improve quality of Investigations
- Delivery of compassionate and trauma-informed care
- Improvements in governance processes
- Attendance for all maternity staff for fetal monitoring training
- Develop and implement a robust process for booking and prioritising women undergoing induction of labour (IOL)
- Review and revise all policies and procedures within the maternity and neonatal service to ensure consistent delivery of care

- Develop and implement a wider engagement plan

Asesiad / Assessment

The maternity and neonatal service at Hywel Dda has undertaken a detailed benchmark exercise to ensure alignment with the priority areas. For each recommendation HUDHB was able to provide evidence to assure against each priority area, with some additional areas for consideration which would further enhance compliance. Further information can be found in appendix 1; HDUHB Benchmark against the SBUHB recommendations, 2025)

- To undertake a national perinatal (maternity and neonatal), quality and safety assessment in partnership with service users, providers and system leaders.
- Identify unwarranted variation in care quality and outcomes in neonatal and maternity services
- Safety and quality concerns are acted on and rapidly improved
- Learning to be shared with health boards as it becomes apparent to allow rapid action to improve the safety of maternity and neonatal care.

This will be achieved by adopting a multi-faceted approach which will be applied to all Health Boards in Wales. A National Perinatal Assurance Assessment Touch Point has been established between NHS Performance & Improvement with Health Board representative (notably the Director and Head of Midwifery) to ensure a cohesive approach and to ensure an opportunity for the cascade of information with the first meeting occurring on the 11th September 2025.

The overall methodology

- Utilise Swansea Bay methodology
- A desk top review of current quality and safety data from health boards (this will be collated from nationally available data with an expectation of HB's to provide locally available data – exact data definitions are yet to be agreed)
- A survey of staff and services user experience (exact data collection methodology to be confirmed)
- Announced site visits on observations of care and service delivery across maternity and neonatal services, this will consider the "15 step methodology" and will focus on appreciative enquiry
- An assessment of clinical governance structure, leadership for risk management, incident management, training, experience feedback mechanisms, workforce planning, acuity assessment, mortality reviews and learning.
- Participation events with women and their families' experiences to highlight areas of concern and improvement. including advocacy groups and charities, obstetricians, midwives and students, and interdisciplinary professional colleagues throughout
- A case note review to ensure compliance with evidenced care standards of a representative selection of cases from 1 July 2025. graded using an established grading

of care scoring system – target is 10% of all births which will equate to a review of 25 casenotes per month

Alongside the Oversight Panel there is an expectation that each organisation will undertake a self-assessment which will include 8 domains,
The 8 Domains of the Organisational Self Assessment, the organisation will select from 4 statements to assess against in each domain:

- Organisational culture and values
- Clinical and professional leadership
- Governance and accountability structures
- Quality of care and service user outcomes
- Staff experience, voice, and engagement
- Service user, carer, and community involvement
- Equity, diversity, and inclusion
- Learning, improvement, and innovation capacity

Early identification of key priorities for Hywel Dda UHB

Having completed a detailed benchmark against the Independent SBUHB report and viewed alongside the information of the purpose and stricture of the Oversight Panel two initial priorities have been identified:

1. Perinatal Engagement Measures (PEMs) are a key recommendation from the Maternity and Neonatal Safety Support Programme and will support a unified approach to data collection of service user experience during pregnancy birth and following birth (with the addition of neonatal unit experience if relevant). The deadline for implementation was September 2025, in order to work towards this deadline a dedicated task and finish group has been established to prioritise this piece of work, and it is supported by the Local Perinatal Champion and Consultant Midwife. Hywel Dda had encountered a number of issues from a data and coding perspective. The PALS team are now prioritising this piece of work to progress to the final stage of implementation which includes local testing to ensure validity. Though PEMs delivered via CIVICA is not yet available, the perinatal service at HDUHB has a breadth of data which provides rich insight into service user experience with a dedicated and concerted effort to ensure that the voice of marginalised groups is also included. Whilst the service recognises the value in PEMs it is important to consider the richness and depth of data around patient experience already readily available at HDUHB.

   Maternity and Neonatal Voices Partnership (MNVP): Paid Chair. The Maternity and Neonatal Safety Support Programme Cymru recommended that each Health Board have a commissioned budgeted MNVP model which includes renumeration of the Lay Chair. The Health Board has previously established a MNVP, however this was on a voluntary basis and engagement of service users reduced over time until it was agreed that the voluntary based model was unsustainable, and the development of a budgeted model was agreed to be necessary to ensure sustainability and alignment across Wales.

A HB specific job description has been developed however in view of the current financial climate in HDUHB and following exploration with the finance business partner, it has not been possible to proceed with the proposal via the maternity / neonatal budgeted establishments and therefore alternate funding sources are being explored which includes the possibility of Charitable Funds on the basis of a fixed term pilot model to enable consideration of long term funding options. An application has been submitted to support the request for charitable funds and work is progressing. Whilst this work progresses, the Maternity and Neonatal service continues to engage with service users utilising mechanisms currently in place which produces both depth and breadth of service user feedback.
Argymhelliad / Recommendation • The Committee are asked to take assurance from the steps taken to assess the safety and quality of services in light of the findings from the Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 6. Person-Centred 3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Not Applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	No financial impact or capital requirements:
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No adverse quality and/or patient care outcomes/impacts anticipated
Gweithlu: **Workforce:**	No adverse existing or future staffing impacts
Risg: **Risk:**	There is a potential risk if the HB is unable to facilitate the reccomendations around service user experience Further information on integrated impact assessment
Cyfreithiol: **Legal:**	No legal impacts or likelihood of legal challenge anticipated
Enw Da: **Reputational:**	Yes, although there are no specific concerns this is potential for political or media interest. Further information on integrated impact assessment
Gyfrinachedd: **Privacy:**	No potential impact on individual's privacy rights or confidentiality and/or the potential for an information security risk due to the way in which information is being used/shared, was identified

Cydraddoldeb: Equality:	The national assessment will underpin the principles of equality, diversity and inclusion. This is especially relevant when outcomes for service who access maternity services are disproportionally poorer if they are marginalised