Submission to Assurance Assessment into Maternity and Neonatal Services in Wales

Sands & Tommy's Policy Unit

Working together to save babies' lives

Sharing insight and evidence from the Sands and Tommy's Joint Policy Unit

- The Sands and Tommy's Joint Policy Unit is focussed on achieving policy change that will save more babies' lives during pregnancy and the neonatal period and on tackling inequalities in pregnancy and baby loss, so that everyone can benefit from the best possible outcomes. We are making this submission to support the work of the Independent Oversight Panel in delivering Workstreams 1, 2, 3 and 5 of their work to assess all maternity and neonatal services in Wales.

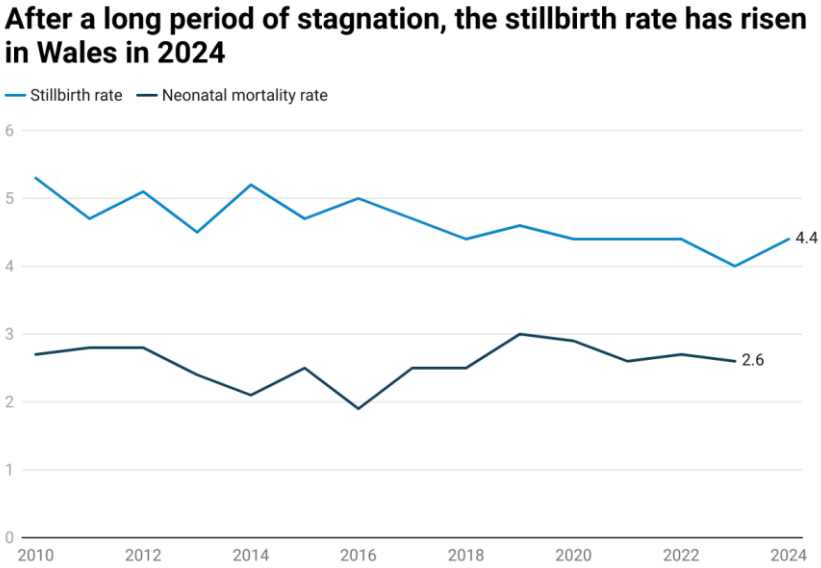
- Currently, there are no targets to reduce baby deaths in Wales. To support progress on the safety of maternity and neonatal services we have called for the establishment of ambitions which are focussed on matching the best-performing countries in Europe for maternity and neonatal outcomes and eliminating inequalities.

- Whilst there is widespread agreement on the need to improve the safety of maternity and neonatal services across the UK, it is less clear what that change would look like. Findings from our recent call for evidence highlighted the need to build consensus on what safe care looks like, with a clear policy approach for achieving it and strong national leadership and accountability to make progress.

- The evidence and insight provided below is structured according to the different areas set out in the terms of reference for the investigation, and we have provided links to sources of information which the investigation team may find useful. A collection of key data on Maternity and Neonatal service in Wales can be accessed on the Joint Policy Unit's Data Hub.

Rates of pregnancy loss and baby deaths in Wales

- Despite a slight overall decline in stillbirth and neonatal deaths in Wales since 2010, this progress has been uneven and not sustained. Compared to the rest of the UK, Wales continues to have a higher stillbirth rate since 2014, and there has been limited progress to reduce neonatal mortality. The stillbirth rates had stagnated in Wales until 2023 and rose in 2024.



- In England there is currently an ambition halve the rate of stillbirth, neonatal death, preterm birth and maternal death and brain injury by 2025. Whilst these ambitions are set to expire, they have provided clear political focus to saving more babies' lives. There are currently no ambitions in Wales.

- To save babies' lives in Wales, we believe that a political focus is required and have proposed that all governments across the UK should unite under renewed ambitions – focussed on matching the best-performing countries in Europe:

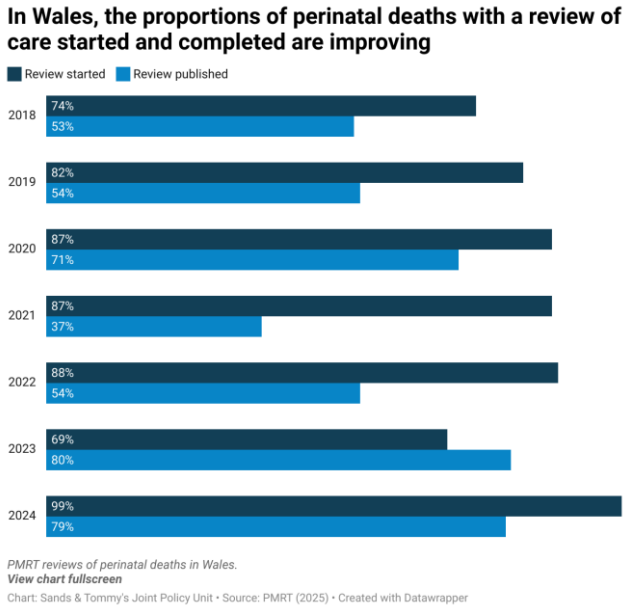
    - A stillbirth rate of 2.0 stillbirths per 1,000 total births.
    - A neonatal mortality rate of 0.5 neonatal deaths per 1,000 live births for babies born at 24 weeks' gestation and over.
    - A preterm birth rate of 6.0% by 2035, with disaggregated data for iatrogenic and spontaneous preterm births.
    - Eliminate inequalities in these outcomes based on ethnicity and deprivation.
    - Establishing routine data collection on miscarriages should be prioritised. Once established, an ambition to reduce the miscarriage rate should be added.

Achieving these ambitions requires transformative change. The Welsh government must make saving babies' lives the priority it deserves to be and introduce a comprehensive, cross-government programme of work to achieve them.

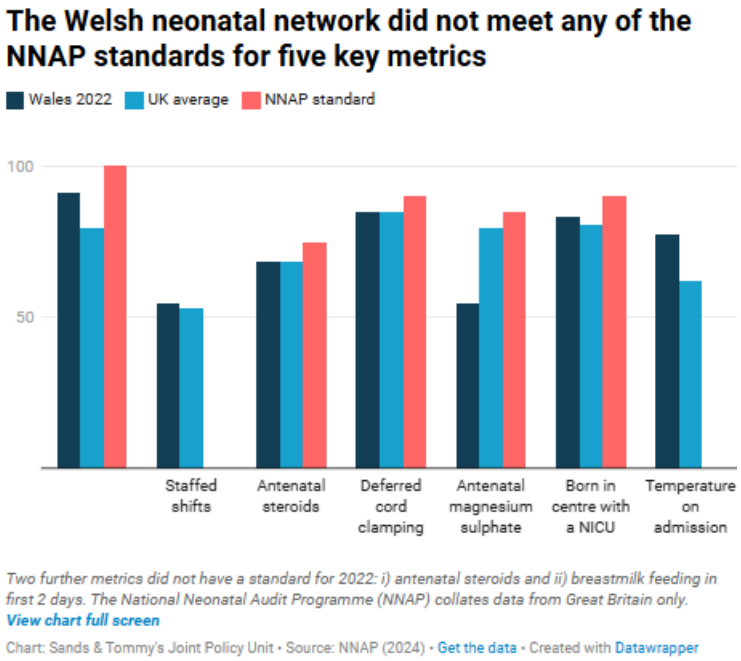
Workstream 1 - Assessment of the data and evidence related to maternity and neonatal services:

Understanding variations in care delivery and compliance with national guidelines at all stages of the maternity and neonatal pathways

- Multiples reports including our annual Saving Babies' Lives Progress Report have highlighted the need to improve the quality and safety of maternity and neonatal services in Wales. To be able to understand the national risks, variations in care delivery and compliance with national guidelines it is essential that all baby deaths are reviewed. According to data from the Perinatal Mortality Review Tool (PMRT), 1 in 5 late miscarriages, stillbirths and neonatal deaths could have potentially been prevented with better care delivered in line with nationally agreed standards. Nearly all (97%) of the reviews completed in Wales during 2023 found at least one issue with the care that was provided. Too often babies are dying because of care that is not in line with nationally agreed standards, including recommendations in the National Institute for Health and Care Excellence (NICE) Guidance, the All Wales Maternity and Neonatal Guidelines or others.
    - Wales had the lowest completion rate for reviews of neonatal deaths across the UK in 2022-23 (54%), lagging far behind England (86%) and slightly behind Northern Ireland (64%) and Scotland (57%).Incomplete reviews mean that any learning for health services and staff are not captured or acted upon, which could lead to mistakes being repeated in the future.



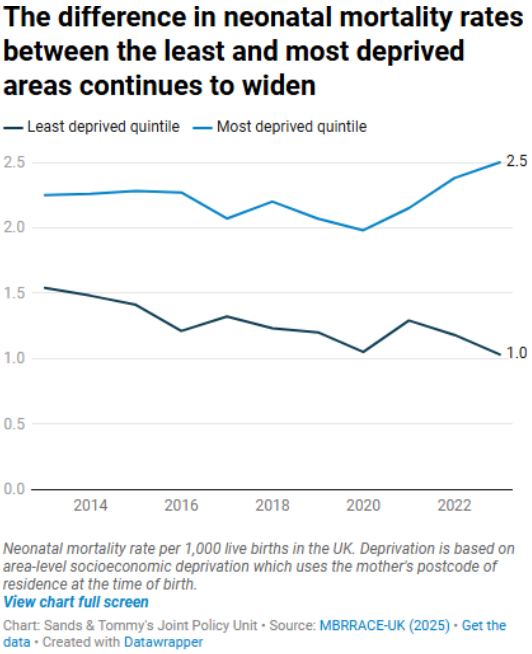
    - The National Neonatal Audit Programme (NNAP) assesses the care provided to preterm babies in neonatal networks across Great Britain. Care is assessed across key measures which are aligned to professionally agreed guidelines and standards. Wales is currently below target for all five metrics with a standard.



- To make progress there needs to be a national focus on addressing unwarranted variation in care.

Identify the quality and safety risks through interrogation of national data to understand specific local and national risks. (Identifying drivers and impact of inequalities)

- Inequalities in pregnancy and baby loss persist across the UK, with stark disparities around ethnicity and socioeconomic deprivation. Women and birthing people from minoritised backgrounds and areas of higher deprivation experience poorer care and health outcomes, some of which is a result of discrimination.
    - Babies from Black and Asian ethnic groups face higher rates of stillbirth and neonatal death when compared to White babies. 2023 data from MBRRACE-UK show that despite a decline in stillbirth rates for Black and White babies, there was a sharp increase for Asian babies. Black babies are still 2x more likely to be stillborn when compared to White babies. Furthermore, the gap between neonatal death rates in the most deprived areas continues to grow when compared to those in the least deprived areas in the UK.
    - Health inequalities may be exacerbated due to geographical constraints and service design, with those in rural communities often having to travel further to receive better care. Further research is needed to understand the extent to which access to healthcare within rural communities in Wales is contributing to health inequalities within materntiy and neonatal services.



- Some explanations include differences in access to, and treatment by, maternity services, health behaviours, and personal and social contexts. Multiple reports have highlighted the impact of racism and discrimination which some individuals experience when engaging with health services. Drivers of inequalities are explored in more detail in the Joint Policy Unit's 2024 Progress Report.

- Better data is needed to identify the groups at most risk of pregnancy and baby loss in Wales as well as understanding what is driving inequalities and identifying potential solutions. Accurate recording of ethnicity data is vital to understanding and improving healthcare inequalities. Despite this, inconsistent coverage and quality within health records within maternity and neonatal care remains an issue. Improving the recording and publication of data on complex social factors would improve insight into the drivers of pregnancy and baby loss.

- Individuals with limited or no English proficiency have often struggled with communicating their needs within the NHS, affecting their ability to meaningfully be involved in their care and contributing to inequalities. Alongside the Swansea Bay University Health Board report which raised issues around language barriers and cultural awareness, the JPUs review into translating and interpreting services highlighted that language needs are not being sufficiently met, with inconsistencies in the provision of interpreters and inappropriate use of family members or staff as substitutes. This idea is further reiterated in the Equality and Social Justices Committee report which noted a failure to provide adequate interpretation was causing medical ham. Not having adequate translation and interpreting services in place can result in missed appointments, delays in care or serious harm in some cases.

Workstream 2- Reviewing previous maternity service reviews from across the UK in the last 10 years.

Highlight recurring themes present in maternity and neonatal services

- Insight from individual reviews is not being used systematically to drive improvements. The last national review of maternity services took place between June 2019 and January 2020 (prior to the Covid-19 pandemic) and found that the quality of care is good and that maternity services in general are delivered in a safe and effective way. However, individual inspections since 2020 have identified patient safety concerns including at Wales's biggest hospital the University Hospital of Wales in Cardiff where the maternity department needs urgent improvement. The independent report into Swansea Bay University Health Board published in July 2025 also highlighted repeated failures in the quality of maternity care despite improvements to staffing.

- It is clear that the system is not properly learning lessons when babies die or listening to the experiences of bereaved families to improve care in the future. The Joint Policy Unit has previously reviewed recommendations relevant to saving babies' lives and tackling inequalities from 30 reports and reviews into the safety of maternity and neonatal services to identify key recurring themes. These are summarised in the table below.

Theme	Description
Staffing levels and training	Staffing levels need to be sufficient to ensure safe care. Workforce plans must be owned by the board with clear mitigation/escalation policies in place when staffing is unsafe. Staff must be suitably qualified with senior staff present on labour wards. All staff must have access to the training that is required for them to carry their roles safely and effectively. To support teamworking, training should be multi-professional and support working together with a shared purpose. It should also include a focus on situational awareness and human factors.
Culture of safety within organisations	Staff must be able to escalate concerns about clinical care whenever necessary, with clear protocols in place to support this. Staff must be able to report safety concerns without fear of reprisal or repercussions. Organisations must review their approach to reputation management and ensure an open learning culture from board to ward level.
Organisational leadership	Safe care must be a shared goal throughout organisations. Boards must take effective ownership of the safety of maternity services with strong oversight of quality and performance of services. Clear arrangements should be in place for sharing patient experience at board level.
Personalisation of care and choice	All women and birthing people should be able to make informed decisions about their care. This includes decisions about mode and place of birth – based on full, impartial information about the safety risks associated with all birth options.
Reducing inequities	Initiatives need to be focussed on improving care for those at increased risk of worse outcomes to reduce rates of miscarriage, stillbirth, neonatal death and preterm birth. This includes accurately recording ethnicity data and using it to respond to risk factors. It also involves working with women and birthing people from minoritized ethnic backgrounds, and other disadvantaged communities, to tailor care and improve outcomes.
Data collection and use	Data collection must help identify variation in outcomes between maternity units, and among different patient groups (for example among women from Black and minority ethnic groups). Steps must be taken to understand the causes of variation and to inform improvements. Better data collection needs to be supported by improving access to digital maternity records.
Learning from reviews and investigations	There should be a standardised, consistent approach to reviews and investigations of serious incidents, with adequate resourcing and families involved in a compassionate manner. Systems must be in place to support the sharing of learning locally, regionally and nationally – with clear actions implemented to address concerns raised.
Engaging with service users	Services must actively engage with, learn from and listen to the needs of women and birthing people. This includes ensuring they are involved in reviews and investigations and consulted on the design and delivery of services.
Delivering care in line with nationally-agreed standards	Reports have consistently highlighted the need to provide timely and responsive care in line with national guidelines. Specific areas that have consistently been identified as requiring improvements are highlighted in Appendix A.

- From our work in this area we've found there is a lack of ownership and accountability for implementing these recommendations. This is explored further in the section on Healthcare organisational leadership, culture and governance.

Workstream 3 – Women, parents and family engagement

Understanding lived experience

- It is welcome that the national assurance assessment is committed to understanding the lived experiences of women, babies and families at all stages of the maternity and neonatal care pathway, hearing directly from those individuals. There must be a commitment to effective engagement throughout the process, including implementation of recommendations. Too often, service user engagement is seen as a single event rather than a continuous process.
    - The Llaise report into the experience of parents who used Swansea Bay maternity and neonatal services found many felt unsafe and unheard during their care. The report supplemented the wider independent review of maternity and neonatal services at Swansea Bay Health Board which was commissioned in December 2023 following several complaints and concerns from families.

- Our recent work on the safety of maternity and neonatal services heard the perspectives of service users and staff on what key changes were needed to make progress on safety. It highlighted areas where greater consensus was required to make progress. A key finding is that while there is widespread agreement on the need for change to improve the safety of maternity and neonatal services - there is not clear agreement on what that change looks like. Stronger national leadership and accountability is needed to make progress. The assessment must build consensus on what safe care looks like and set out a clear policy approach for achieving it.

Workstream 5 – Healthcare organisational leadership, culture and governance

Culture of safety

- Whilst the Maternity Neonatal Safety Support Programme Cymru found that services across Wales were 'making progress' to integrate ideas and processes around the Institute for Healthcare Improvement Framework for Safe, Reliable, and Effective Care, they are yet to become standard practice with some staff still describing issues with a blame culture, lack of teamwork and issues with communication.

- Our call for evidence on the safety of maternity and neonatal services highlighted a lack of a shared understanding of what is meant by 'safety'. Some people interpreted this as improving outcomes, with a focus on reducing preterm birth and perinatal mortality, whilst others focused on ensuring pregnant women and birthing people have a positive experience. There was also discussion around taking a broader view of safety which incorporates personalisation of care and considers future potential pregnancies. While there is widespread agreement on the need for change to improve the safety of maternity and neonatal services, it is not clear that there is agreement on what that change looks like.

Lack of accountability for progress

- We have previously highlighted how lack of accountability is a significant barrier to progress. This includes accountability of the NHS nationally, arms-length bodies, as well as professional and representative bodies.

- To move forward effectively we need much stronger national leadership, clear accountability for delivery and genuine oversight of progress. Currently we don't build consensus on how recommendations should be implemented, or the resources needed to implement them effectively.

- With multiple recommendations from different reports which don't always neatly fit together, we need national leadership that is able to prioritise and sequence them which makes a clear determination of who is responsible for delivering on them. Stronger leadership is also needed to ensure that those organisations tasked with delivering on recommendations have the capacity, willingness, and ability to do so.

Lack of effective evaluation

- To make progress we need a commitment to evidence-based policy and rigorous evaluation of what works. The initiatives that have been introduced in response to concerns about the safety

of services often lack a strong evidence-base or have weak or non-existent evaluation. A renewed policy approach to improving the safety of maternity and neonatal services must ensure changes or initiatives intended to support improvement are carefully evaluated.