Maternity and Neonatal National Assurance Assessment
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Terms of Reference

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1. Introduction

Maternity and neonatal services across the UK strive to provide safe and high-quality care, but concerns persist regarding variation in safety and quality. Many maternity and neonatal services have been subject to high-profile retrospective reviews following serious quality and safety concerns and systemic failures. In April 2019, following serious concerns, the maternity and neonatal services at Cwm Taf Morgannwg University Health Board were placed in special measures and an independent review was undertaken.

The publication of the Llais Swansea Bay University Health Board Maternity Services Insights Report in May 2025, set out the experiences from 512 people who had used maternity services in Swansea Bay within recent years, about their journey through pregnancy, birth, and postnatal care.

In July 2025, the independent review of maternity and neonatal services at Swansea Bay University Health Board report was published. In addition, the Swansea Bay maternity support group published its family led review into Swansea Bay maternity services with over 50 families contributing to the report. All three reports highlighted unacceptable patient and family experiences, cultural issues, staffing, training and resource issues, environmental and safety concerns.

Following the publication of the Llais report the Cabinet Secretary for Health and Social Care commissioned an assessment to assure whether maternity and neonatal services across Wales provide safe and compassionate care and whether services have learned from the reviews which have been carried out into services in Wales and across the UK.

2. Rationale

The Welsh Government quality statement builds on the 5 year vision for the future of maternity care in Wales (2019) which is focused on achieving high quality maternity services in Wales – what good looks like. The Welsh Government Is seeking to gain assurance on where we are now with improvement efforts, and understand what needs to be done next to build continuous service improvement, how health boards engage women and families earlier in their individual investigation reviews, and reduce delays to responses when women and families need answers to their questions and concerns.

This nationally commissioned assurance assessment is part of a suite of interventions which the Welsh Government is committed to in order to ensure that the maternity and neonatal safety support programme remains contemporary and responsive to changing evidence for improved outcomes. It will ensure that the lived experiences of women, babies and families, are fully heard and used to inform the development of the national recommendations. Of equal importance will be the voices of staff, and their experiences of working in these services. It should be noted that in Wales, the staff working in maternity services, may have had need to use the services in the past. The assessment will focus on assessing the quality and safety of maternity and neonatal services across Wales. It will identify areas of good

practice and those where there may be residual risk or concern within maternity and neonatal care. It will gather intelligence using a multi-method approach, providing insights and findings for the Independent Chair and Assessment Panel.

3. Aims

The aims of the assurance assessment are to:

- Provide assurance on the quality and safety of maternity and neonatal services and develop a set of national recommendations.
- Promote equity and consistency by identifying and addressing any unwarranted variation in care quality, outcomes.
- Ensure the lived experiences of women, families and staff are heard and inform the national recommendations.
- Accelerate improvement by capturing, celebrating, and spreading learning from exemplary practice across all services.
- Strengthen national oversight of perinatal (maternity and neonatal) quality and safety through a unified, experience-led and evidence-based rapid assessment, undertaken in partnership with women and families, staff, providers, and system leaders.
- Safeguard women, families and staff by ensuring that any quality or safety concerns are rapidly identified, escalated, and resolved, with measurable and sustained impact.

4. Objectives

The objectives of the assurance assessment are to:

- provide a current-state assessment of the quality and safety of perinatal services in each health board across Wales, supplemented by a national overview.
- undertake a national whole-system, evidence-informed quality and safety assessment of perinatal services in partnership with women and families, staff, providers and system leaders, with outputs described at a health board and national level, in a report for the Cabinet Secretary for Health and Social Care.
- ensure that any emerging safety and quality risk or concerns are acted on and rapidly improved, so services are consistently safe and of high quality.
- assess any variation in care quality and outcomes across the range of perinatal pathways.
- ensure that exemplary practice is identified and shared for national adoption.
- ensure insights from women and families, service users, staff, providers, and system leaders inform evidence-based recommendations.
- further develop actionable assurance measures that support sustainable improvements and equitable care.

The assessment will be undertaken against key criteria in the national Quality Statement and Quality Standards, together with the supporting enabling actions.

5. Scope

This assurance assessment will provide a proportionate and, in the main, contemporaneous assessment of perinatal (maternity and neonatal) services delivered by health boards across NHS Wales. By contemporaneous, we mean grounded in the present: a snapshot of today's practice, culture, and experiences. While the assessment will include some retrospective analysis of relevant data and evidence, it is not intended to be a retrospective review. Instead, its focus will be on a representative range of current service settings and points along the perinatal pathway, assessing the integration of perinatal services, governance, leadership, quality-driven data, current arrangements, culture, and outcomes to identify strengths, opportunities for improvement, and any areas of concern that require prompt action. The focus will be on clinical care undertaken within 2025. Taken together, the findings will provide a clear and balanced picture of perinatal services across Wales for assurance.

6. Methodology

The approach will incorporate a multi-method assessment to allow triangulation of evidence against the NHS Wales Quality Statement. This process will consist of individual workstreams and developed in collaboration with the independent chair and the expert panel. The workstreams will incorporate:

- The views of women and families
- A desktop review of national and health board data held by NSH P&I
- A desktop review of national (UK) recommendations in previous maternity and neonatal reviews, and the impact.
- Family engagement events, to include ethnic minority, seldom heard communities and inequalities groups.
- Healthcare professional engagement events.
- Data from organisational self-assessments.
- Clinical site visits across maternity and neonatal pathways, antenatal care, postnatal, labour ward and community.

Any safety and quality concerns as well as areas related to exemplary practice highlighted through the process to the assessment panel must be escalated to ensure immediate action

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

- Identify the quality and safety risks through interrogation of national data to understand specific local and national risks.
- understanding variations in care delivery and compliance with national guidelines at all stages of the maternity and neonatal pathways
- Understand the level of resilience in maternity and neonatal systems to enable the service to identify and manage risks for individual cases.

- Understanding risks in the models of care delivery in maternity and neonatal services provided across the unique context in Wales.
- Understand the quality and reliability of care provided for those with increased risks.
- Identify recruitment, retention, education and training issues, including staffing challenges across medical, midwifery neonatal nursing and support staff across the whole pathway.
- Examine how national best practice is identified and implemented in health boards and how this is shared to enable adoption.

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
- Highlight strengths in Wales by understanding how many of those recommendations have been implemented and the impact thereof.
- Understand any barriers as to why those recommendations have not been adopted or fully implemented
- Highlight any risks or deviation particular to the Welsh context.

Workstream 3 – Women, parents and family engagement

- Engage widely across all regions in Wales, to understand learning from the positive experiences of women, babies and families and from those who have been harmed during the delivery of maternity and neonatal care.
- Fully hear families around their expectations for safe, compassionate care in maternity and neonatal services.
- Understand how debriefing services and 'putting things right' process can support health boards to engage women and families earlier in their individual investigation reviews and reduce delays to responses when women and families need answers to their questions and concerns.

Workstream 4 - Understanding the experiences of staff in perinatal services

- Engage widely across all regions in Wales, to understand the experiences of the workforce (multi-disciplinary teams) working in maternity and neonatal care.
- Understand the culture of care and compassion, whether psychological safety and freedom to speak up is embedded in maternity and neonatal services
- Understand whether the MDT's reflect the characteristics of high performing teams, especially related to innovation and creativity, and responses when things go wrong in the delivery of care in in maternity and neonatal services.
- Understand whether restorative and supervisory practices are in place to help staff who find themselves part of an investigation learn and remediate practice as part of the MDT?

Workstream 5 - Healthcare organisational leadership, culture and governance.

- Examine the effectiveness of organisational leadership, reporting and governance, how organisations respond when things go wrong (culture) and consider accountability, using an adapted IHI SREC tool, strengthened with 'well-led' components.
- Understand variation and effectiveness in organisational leadership, accountability and governance mechanisms in maternity and neonatal services.
- Evaluating current reporting mechanisms from ward to board on safety, reliability and effectiveness, of delivery of maternity and neonatal services
- Understanding the executive and board culture to adopt continuous improvement approaches in maternity and neonatal services for sustainable improvement.
- Understand the organisational culture and accountability mechanisms that encourage psychological safety and freedom to speak up.
- Evaluate the effectiveness of existing accountability arrangements across NHS Wales and the role of national organisations and regulators in identifying and responding to serious issues.
- Examine the quality of PMRT/ NRIs, including the investigation processes and whether there is evidence of learning from incidents and the duty of candour is promoted and supports open, transparent discussions with those harmed.
- Understand how families are kept informed, with clear and accurate information, and involved and input into their investigations.
- Evaluate the quality of responses to investigation or complaints to determine whether compassion and kindness are centred for women, babies and families when things go wrong.
- Assess the quality and consistency of bereavement care for women and families in maternity and neonatal services.

Workstream 6 - Site visits

- Using an adapted 15 steps methodology provide real-time insights into the maternity and neonatal environment and provide first impressions of care from the perspective of women, families, and staff, enabling triangulation of what is observed with what is reported.
- Inviting the family representation to undertake site visits with panel members to evaluate the culture and the environment of care.
- Speaking to staff on the visit to gain further insights into the local unit's culture: where excellent care delivery has been identified and in safety and managing risks, escalating when things go wrong.

7. Stakeholders

<u>Women, families, and communities</u>

- Women with recent lived experience of maternity and neonatal care (including positive, negative, and complex cases such as stillbirth, preterm birth, disability, or neonatal death).
- Partners, families, and carers of those who have used services.
- Representatives from seldom-heard communities including but not limited to global majority groups, LGBTQ+ families,

people with learning disabilities, migrant or refugee women and women with substance misuse or safeguarding concerns.
- Parent and patient advocacy groups:

<u>Maternity and neonatal workforce</u>
- Midwives (including student, community, hospital-based, and consultant midwives)
- Neonatal nurses
- Obstetricians
- Neonatologists and paediatricians
- Anaesthetists and perioperative workforce
- Resident doctors and students
- Perinatal mental health specialists
- Allied health professionals
- Health visitors
- Maternity support workers
- Educators

<u>Clinical and organisational leaders</u>
- Directors and Heads of Midwifery
- Clinical Directors of maternity and neonatal services
- Executive Directors of Nursing and Medical Directors
- Chairs and Chief Executives of health organisations
- Clinical governance leads
- Quality and safety leads
- Llais, HIW, HEIW and Royal Colleges - Royal College of Midwives (RCM), Royal College of Nursing (RCN), Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Paediatrics and Child Health (RCPCH), Royal College of Anaesthetists (RCoA), Neonatal Nurses Association
- Health professions regulators – GMC, NMC, Health and Care Professions Council

8. Governance

The assurance assessment has been commissioned by the Cabinet Secretary for Health and Social Care. The assurance assessment will be led by the Independent Chair, supported by a panel of experts and a stakeholder panel with an interest in improving the quality of maternity and neonatal services. The Chair will be supported by a multidisciplinary project team.

All records and data relating to the assurance assessment will be processed according to the agreed information sharing agreements and data protection requirements.

9. Communication

Learning will be shared with health boards as it becomes apparent enabling any rapid action that may be required to improve the safety of maternity and neonatal care.

Regular progress updates will be provided via the NHS Wales Performance and Improvement website.

The final report, recommendations and health board assessments will be publicly available.

10. Timescale

Assessment	August – December 2025
Final Report	January 2026

11. Version Control

Version 1	July 2025	Draft version for consultation with families and stakeholders
Version 2	July 2025	Amendments following consultation
Version 3	August 2025	Amendments following consultation
Version 4	August 2025	Amendments following consultation
Version 5	August 2025	Draft shared with Cabinet Secretary
Version 6	September 2025	Draft to first panel meeting for review
Version 7	September 2025	Draft following first panel meeting
Version 8	26 September 2025	Approved by Independent Panel