All Wales Perinatal Assessment SBAR and its impact on the SBUHB Perinatal Improvement Plan

March 2026

Situation

The 'Path to Safer Beginnings in Wales' is the national assurance assessment of maternity and neonatal care and services (known in its scoping and consultation phase as the All-Wales Perinatal Assessment set). The document, published in February 2026, is an independent report about maternity and neonatal services across Wales. It assesses the quality, safety, equity and consistency of care. It includes a series of recommendations to be implemented on a national level over the next three years.

SBUHB has its own Perinatal Improvement Plan (PIP), in response to concerns raised about maternity and neonatal care through several reviews, including the Independent Review into Maternity and Neonatal Services in SBUHB.

The purpose of this document is to compare the recommendations of the All-Wales Assessment to the PIP and propose actions for any gaps or variations in recommendations at an All-Wales level with the local plan.

Background

The Cabinet Secretary for Health and Social Care commissioned the assessment in May 2025 following significant concerns raised in recent reviews, including those relating to Swansea Bay University Health Board. These reviews highlighted unacceptable experiences, cultural issues, safety risks and variation in care.

An independent expert panel oversaw the work and led a whole-system, multi-method approach across Wales. The panel met between September 2025 and January 2026. Several members of the expert panel are also members of the Independent Oversight Panel in SBUHB.

Assessment

The Path to Safer Beginnings in Wales document has eight thematic recommendations. These are described by the report as priority areas, intended to remove the uneven delivery of care across Wales.

1. Joined up national perinatal leadership
2. Universal offer of high-quality care
3. Urgent attention to critical clinical safety systems
4. Enough staff and the right spaces to care safely
5. Support for mental health and wellbeing
6. Improved planning and commissioning for neonatal care
7. Learning from reviews with families involved
8. Listening, understanding and improving through real feedback

Several of the recommendations have a focus on nationally led programmes or policy setting decisions that require further clarity and specificity from Welsh Government on next steps. However, there are some enabling actions at a local level. To best understand where action may be needed, the key actions for each header, along with a comparison with PIP are highlighted in Table 1.

Table 1: Key actions and comparisons

Specific action	Nationally or HB-led?	Does the PIP or business as usual activities provide adequate cover/mitigation?
Recommendation 1: Joined up national perinatal leadership		
1a National Perinatal team and oversight board	National	N/A, however we may be asked to contribute expertise to the various proposed structures. No action needed.
1b Data and monitoring	National	Welsh Gov action to implement MOSS and additional safety signals. We are already undertaking local actions to improve live reporting and monitoring of safety information. Action ongoing (BAU maternity dashboard / Awaiting confirmation of action on MOSS from WG.
1c National governance	National	N/A
Recommendation 2: A universal offer of quality care throughout the perinatal journey		
2a Assess the current rates of continuity of care by midwives in 2026/27, leading to a plan to be coproduced with Welsh Gov, HEIW, HBs, staff, women and families to increase continuity of care	National with HB input	N/A currently – ER seeking clarity with CNO (Sue Tranka) on whether this is likely to reflect the model adopted in England. Awaiting confirmation of action.
2b Critical safety pathways before, during and soon after birth – implementation of national service standard specs on triage assessment and induction of labour.	National	We have already implemented BSOTS for triage assessment. No action needed (PIP1 / BAU). We are redeveloping our SOP on induction of labour, including a risk assessment, as part of Badgernet implementation. Action ongoing (PIP1) We will develop a plan to incorporate national standards into our processes once published. Awaiting confirmation of action.
2c Postnatal care – actively progress UNICEF UK Baby Friendly Initiative accreditation Routine offers of birth discussions for women before discharge from maternity services, and including neonatal services where appropriate.	HB HB	No action needed. The Neonatal Team successfully re-accredited late last year (2025). Following Maternity's initial assessment, the service achieved compliance with 80% of the required standards. The remaining nine standards are scheduled for assessment in June 2026, after which full accreditation is expected

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Provide clear, accessible and accurate information to the public via social media templates to address misinformation.	National	Debriefs already in place. No action needed (BAU) Welsh Gov leading, adapt templates when received at local level. Suggest testing via engagement routes to ensure adaptions are appropriate for local audience Awaiting confirmation of action.
Recommendation 3: Urgent attention to critical clinical safety systems		
3a Welsh Gov to commission and implement national triage line at pace in 2026. Welsh Gov to publish a standardised service model for in-person triage with consistent terminology, ensuring 24/7 availability supported by dedicated staff and reliable senior clinical presence	National National	Await Welsh Gov next steps – CD of Midwifery on steering group. Mitigation in place locally through single point of action maternity triage line. Awaiting confirmation of action. / Mitigation in place in interim via SBUHB single point of access maternity triage phoneline. Await publication of model and review our model accordingly Action ongoing (BAU) / Awaiting confirmation of action from WG and will review our model against standardised model.
3b Clear national service specification model on induction of labour, including admission pathway, place of care, dedicated workforce and discussion of induction of labour capacity and flow in daily perinatal MDT 'huddles'	National	Await Welsh Gov next steps. However, we are reviewing Induction Of Labour SOP locally so can incorporate elements detailed in high level action. Awaiting confirmation of action / Action ongoing (PIP1 and BAU)
Recommendation 4: Adequate staffing and estates to deliver safe and quality care		
4a Development and implementation of a workforce planning tool for a MDT workforce model for maternity services, to mirror and integrate with the BAPM standards for neonatal services. This should include adequate levels of allied health professionals, psychology and pharmacy, and should replace the current mandatory use of Birthrate Plus. Health Boards to address immediate staffing pressures by:	National HB	Awaiting confirmation of action / Current mitigation in place and using the mandated Birth Rate Plus Midwifery Staffing assessment tool – midwifery staffing compliant to this assessment – due for re assessment in 2026. • Obstetric, Midwifery, Neonatal and Neonatal Nursing staffing and skill mixes regularly reported through Perinatal

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• Undertake a detailed review of their obstetric workforce provision in relation to service capacity and the needs of women and families. • Review sufficiency of the allied health professionals and psychologists in maternity services, ensuring alignment with BAPM standards for neonatal services and develop implementation plan to address gaps in provision. • Review current staffing levels and skill mix of midwives and neonatal nurses, ensuring at a minimum they are meeting current Welsh Gov guidance for the use of Birthrate Plus in Wales and BAPM standards.	HB HB HB	governance framework, using AAA for escalation of concerns around gaps in provision. No action needed. • Action ongoing - Business case required as no AHP and Psychology provision in Maternity (PIP3) – Neonatal AHP provision included in Perinatal Committee workforce metrics • Action ongoing - Maternity - Birth Rate Plus compliant – due for re-assessment in 2026. • Action ongoing - BAPM compliance reported via Perinatal Committee workforce metrics. HEIW launched QIS (Neonatal Nursing) Framework in March 2026 – service to benchmark against this model. Grow your own programme embedded to support service ability to comply and future proof to BAPM standards – needs to be included in PIP3.
4b NHS Wales JCC to commission a maternal medicine clinical network. Also NHS P&I should facilitate review of clinical pathways for rare but serious pregnancy-related conditions.	National	No action needed
4c Each HB should review their theatre estate and capacity, reflecting current and future need, incorporating a plan for theatre staffing and that maternity theatres are appropriately located and equipped within the maternity and neonatal service footprint to ensure timely MDT care for women and babies during planned and unplanned surgery.	HB	Additional theatre business case under development. Working with Capital Bids team. Action ongoing (PIP1)
Recommendation 5: Mental Health Support		
5a Welsh Gov to develop a national service specification for perinatal mental health pathways that encompass both common mental health conditions and moderate to severe conditions experienced by women, as well as services for fathers/partners and parent-infant relationships.	National	Awaiting confirmation of action

Specific action	Nationally or HB-led?	Does the PIP or business as usual activities provide adequate cover/mitigation?
5b HBs to ensure that training is embedded for all staff in perinatal services on recognising, responding to and preventing trauma. This should also be completed by all involved in responding to incident processes, including legal teams.	HB	Action ongoing (PIP3) – development of training offers underway, reviewing alignment with training offer for Listening To People to understand if this can be adapted or whether bespoke perinatal model is needed.
5c Each HB should engage in a meaningful process with staff in perinatal services to seek an in-depth understanding of staff mental health and wellbeing needs and coproduce improved support and care structures. HBs should review and monitor the effectiveness of this through collaborative and transparent methods engagement.	HB	Action ongoing (PIP3) – development of the Staff Wellbeing and Retention (SEWR) Plan has involved listening and learning from staff on a host of topics, including staff mental health and wellbeing needs. SEWR to launch by June 2026 and will include ongoing work groups with staff involvement to continue coproduction and evolve using staff feedback. Use of flash surveys on quarterly basis being explored, as well as potential pilot programme of "rate my shift" app, which will provide real time data on staff sentiment.
Recommendation 6: Optimal neonatal care commissioning		
6a Urgent need for the NHS Wales JCC to complete required analysis and commissioning decisions relating to neonatal cot configuration and neonatal transport, including consideration of how to maximise the quality and capacity of transitional care.	National	No action needed
6b Welsh Gov to accelerate plans to implement a national maternity bed and neonatal cot finder service, based on a standardised model with 24/7 availability, dedicated staffing, robust senior clinical oversight and a single consistent telephone access point to ensure safe and timely system wide coordination.	National	No action needed
Recommendation 7: A reliable process for review and investigation, that involves families and leads to timely learning		
7a A clear, accessible, publicly available SOP for maternity and neonatal services in Wales for incident response and management, including flowchart that demonstrates the process and timescales that must be followed to align with Welsh legislation and guidance, and UK frameworks. Family-centred and trauma-informed, using restorative justice approaches.	National	Awaiting confirmation of action / however we are exploring developed of our own Harmed Patient Pathway model (PIP2).

Specific action	Nationally or HB-led?	Does the PIP or business as usual activities provide adequate cover/mitigation?
7b Specialist Committee of National Strategic Oversight Board to oversee HBs' operation delivery of the perinatal National Reportable Incident Process	National	Awaiting confirmation of action
7c A national perinatal repository to include local and national reportable incidents, which would enable and report on systematic and meaningful learning.	National	Awaiting confirmation of action
Recommendation 8: Developing an in-depth understanding of need, experience and outcomes through engagement and evaluation		
8a HBs improve how women's, families' and communities' experiences and views are heard and acted on by optimising the implementation of the Perinatal Engagement Framework.	HB	Action ongoing (PIP2 and BAU use of Perinatal Engagement Framework)
8b HBs should improve how the experiences and views of staff are heard and acted upon by implementing meaningful involvement approaches that are co-produced with staff groups.	HB	Action ongoing (PIP3 via SEWR plan)
8c WG to commission a programme of research on the costs and short, medium and long-term consequences of the current and emerging model of care.	National	No action needed
8d HBs to test and evaluate initiatives to reduce inequalities of experience and outcome, particularly relating to poverty and ethnicity, and share findings at an all-Wales level.	HB	Action needed – seek support from Public Health team to map initiatives and understand their impact against maternity and neonatal outcomes.
8e WG should commission an evaluation of the impact and outcomes of priorities recommended here.	National	No action needed

Recommendations

Be Assured: Through comparison with the key actions for highlighted by the 'Path to Safer Beginnings in Wales', the organisation can be assured that most actions required to be undertaken by Health Boards are either in train or form part of the Perinatal Improvement Plan or perinatal business as usual. Of note, all deemed to be critical clinical safety actions, are already underway in SBUHB.

Be Alerted to: Actions that are not explicitly covered by the PIP or business as usual and will require a response. Specifically: *8d HBs to test and evaluate initiatives to reduce inequalities of experience and outcome, particularly relating to poverty and ethnicity, and share findings at an all-Wales level*. It is proposed that support is sought from the Public Health Team on how we progress develop a plan with appropriate evidence-based methodologies and measures to successfully evaluate such initiatives.

Be advised: There are some actions that it may be prudent to pause on, pending further steer from Welsh Government, such as 7a around incident response and management, specifically around trauma-informed, restorative justice approaches. However, it should also be noted that the Welsh Government programme is intended to take three years to deliver, while timescales against majority of SBUHB actions are to be completed by end of 2026, so may require a steer from Welsh Government on acceptability where we deem it to be beneficial to wait for national guidelines.

ENDS