Summary of SBUHB Board Perinatal reports Jul 25- May 26

Date of Public Board Meeting	Agenda Items	Extract of Minutes	Link to Board Reports
July 2025 Special Board	2.1 Maternity & Neonatal External Review Report	JW welcomed DC and KS, extending the Board's grateful thanks to them and all members of the IR team for the robust, objective and independent scrutiny that underpinned the report and for the 'blueprint' it offered to develop excellent services, through learning and improvement. DC thanked JW and made some introductory remarks: the report summarised the experiences of over 1000 women and families, and DC thanked them all again for their preparedness to relive distressing and traumatic times. They had done so in the expectation that SBUHB would learn from them and take immediate and sustainable action to improve services. Using a slide presentation, DC summarised the background to the commissioning of the report: the HIW report; MBRRACE reports; and the significant concerns raised by families. The report comprised five components: • The voices of families, reported in a raw form, which came through loud and clear. • The clinical review of cases undertaken by experienced independent clinical experts. • Governance and culture, with a 'Board to Ward' review of systems, processes and controls. • Staffing and leadership across maternity and neonatal services. • Data and context, including staffing numbers, demographic risk data, incident numbers and outcome data. DC drew the Board's specific attention to the population health data and associated population-level risks. On engagement with women and families, DC drew attention to: • KS' lead role; his background and experience would be valuable in supporting SBUHB in resetting its family and community engagement methodology and in driving improvements. • The Family Engagement and Outreach Team had sought to engage people in a number of ways, including through: GP surgeries; local Mosques; traveller communities; the DVLA, as a major employer in the SBUHB area; and sessions in local shopping centres. 1180 women and families had voiced their concerns and experiences, overseen for assurance purposes by a Family and Community Voices Steering Group, with	Special Board - July 2025 - Swansea Bay University Health Board

		representational family attendance. DC also acknowledged the Llais report and the valuable insights and themes from that; the IR report had incorporated those themes. DC also acknowledged the significant contrition made by the FLR. • The thematic analysis included all sources of feedback, with the following key findings: • Many women reported mostly positive experiences in pregnancy; the report focused on those women who had experienced poor experiences, including severe birth trauma. • Whilst many concerns related to the period pre-2024, some experiences were more contemporary. • Concerns related primarily to: communication and advice; birth trauma and fear; being ignored and not being listened to; and a lack of compassion. These issues had undoubtedly impacted adversely on informed decision making. • Separation from birth partners, both during and in the years following, the COVID-19 pandemic, with a 'rule-bound' approach evident. • The views of some seldom heard groups on issues including communication, where a language line alone had proved insufficient to ensure effective communication, together with a lack of cultural awareness and sensitivity. DC emphasised that people had shared their stories because they wanted to work with SBUHB and secure improvements. • Families were not moved to attend formal meetings, their preference being to engage in their local, community settings, with SBUHB professionals coming to them to seek their views; this was an important message for SBUHB to hear in resetting engagement arrangements. • Changes already made included: • Changes in SBUHB senior leadership. • The Board's recognition of, and apology for, letting women and families down; there was more to do to embed a comprehensive co-produced and co-designed model. • Important public statements made by the Chief Executive in recognising the failures; action had to follow. • A small number of meetings between the Chair and Chief Executive with a small number of families; these should continue as families appreciated them. On the <u>clinical case reviews</u>, DC highlighted:	

		• The methodology adopted, using two multidisciplinary teams, with care assessed against contemporary clinical evidence and standards. • The ongoing feedback provided to the service on those areas that required urgent action. • The maternity triage system: this was a high-risk area as the first port of call for women; this needed to improve to ensure that senior experienced staff undertook the assessments. • The Induction of Labour pathway; this required strengthening. • Whilst staffing numbers had increased, experienced staff had also moved on to new posts or retired; consequently, the service had a disproportionate number of inexperienced staff requiring senior oversight, with a similar position in the neonatal service. • Enhanced midwifery care, utilising the Midwifery Early Warning System (MEWS) was in place at the Singleton Hospital site but not yet at other locations; this needed addressing. • There was a lack of rigour in the conduct of incident reviews; families did not feel engaged with the process and letters received lacked compassion. • Changes already made included: • The recent introduction of the Birmingham Symptom Specific Obstetric Triage System (BSOTS) to assist in categorising and prioritising care; this was a very positive change but further progress was needed on the quality of calls and the monitoring of family experiences. This issue was not unique to SBUHB, with most Care Quality Commission (CQC) maternity reports in England identifying triage as an area of concern. However, the position in SBUHB required significant and urgent improvement. • Funding secured to support foetal monitoring capability, supported by clear guidance and pathways. • Practical Obstetric Multi Professional Training (PROMPT) was now in place, along with development programmes for midwives to enhance competencies. On <u>Leadership and Staffing</u> the key findings centred on: • The loss of a number of senior and experienced staff post COVID-19, with low staffing levels impacting on service users. • Insufficient staffing, leading to incidents. • A lack of oversight of rosters, leading to incidents.	

		• Staff inability to attend mandatory training, due to low staffing levels. • Limited escalation of staff concerns. • Changes already made included: • A significant increase in staffing levels, with the service now close to its staffing establishment levels; however, this did not address the need for more senior and experienced staff. • Change in leadership. • Significant improvements made in medical workforce numbers. • Investment in training, associated with a significant improvement in compliance. • A high incident reporting rate; whilst this sounded counterintuitive it demonstrated good follow through. There was more work needed to ensure that this happened for all incidents. • Improved feedback for student midwives and trainees. On <u>Governance</u> the main findings were: • Significant weaknesses, particularly related to limited staffing and associated risk management. • The management of debriefs; families reported delays, with the process appearing formulaic. Whilst improvements were evident, families held an overwhelming view that the complaints process was not working. • The need for improvement in incident investigations, to comply fully with MBRRACE processes. • Families must be at the centre of investigations. • Changes already made included: • A change to key SBUHB senior leadership posts. • Transfer of responsibility and accountability for complaints management to the Executive Director of Nursing. • Silver and Gold Command arrangements and enhanced reporting to the Board in greater detail. • Improved data capture, through the neonatal dashboard. • A debrief process was in place, with further refinements needed. • Improved family involvement in the investigation process. • Increased staffing levels; this had resulted in a change in the ratio between senior, more experienced and junior, inexperienced staff, and it warranted attention. • A reduction in sickness rates.	

		• The majority of staff being compliant with mandatory training requirements. • A gradual downward trend in MBRRACE data. • A significant reduction in Hypoxic Ischaemic Encephalopathy over the past year; detailed analysis of each case was imperative. • Positive working relationships reported between maternity, medical staff and neonatal teams. • Greater staff confidence in raising concerns, with further requirement necessary. **The Recommendations** Introducing the Recommendations, DC acknowledged the risks associated with the receipt of multiple reports, all of which included recommendations. There was a need for clear ownership, with timelines against delivery and a transparent accountability process. The IR report had a series of recommendations and DC drew particular attention to the corporate recommendations; these required the Board's specific and early attention. 1. Establishment of a single point of access for maternity triage for all women; currently low birth, home pathway and midwifery led maternity fell outside the maternity triage system. This posed a high risk, and the Board should set up a single contact triage process for all women. There was national guidance available, and the Board should exercise close oversight of the model introduced. 2. Delivery of consistent care with oversight from senior clinical staff across all services, with obstetric procedures overseen by senior and appropriately experienced staff. 3. Implementation of Maternity Early Warning Scores (MEWS) – this was in place at the Singleton site but required roll out. 4. Improvement in the quality of investigations, involving appropriate multidisciplinary reviews, and conducted within reasonable timescales, in line with MBRRACE and serious incident review guidance. There should be a clear trigger for independent or external review. 5. Delivery of compassionate and trauma informed care; recently published literature set out the importance of what families wished to see regarding openness and transparency. Compassionate care should be the norm. 6. Improvements in governance processes, including a complete review of governance and reports that highlight issues clearly to the Board.	

		7. Attendance by all maternity staff at the all-Wales education programmes on foetal monitoring. DC drew attention to recent developments that would support this. 8. Development and implementation of a robust process for booking and prioritising women undergoing induction of labour; national advice had changed and had to link with information to families. Review and revision of all policies and procedures across maternity and neonatal services to ensure consistent delivery of care. Development and implementation of a wider engagement plan to improve the way that SBUHB engaged with women and families, avoiding an over reliance on surveys. In addition to these Board-level recommendations, DC took members through a further eleven recommendations designed for Welsh Government (WG) and other national bodies: 1. Review of the Putting Things Right guidance. 2. Introduction of a Harmed Patients Pathway (all disciplines). 3. Mental health support for women and families; this required an all-Wales approach. 4. Support for the Welsh Risk Pool to achieve its potential in terms of data, benchmarking, and providing helpful insights, with more resource available to adopt the thematic principles of the Patient Safety Incident Response Framework (PSIRF). 5. The Maternity and Neonatal Clinical Network lacked clarity in its function between strategy and operations. 6. A need for a review of the capacity of neonatal critical care services in Wales. 7. Recent changes to the approach to babies born at extreme preterm gestational ages (less than 24 weeks gestation) in the UK were likely to result in a significant increase in demand for neonatal intensive care. 8. Healthcare providers and commissioners needed to look actively at high-risk clinical services and seek assurance that outcomes were in line with national standards and that services were safe. 9. This review had highlighted shortages in paediatric radiology support 10. Prompt reporting of postmortem results was key to answering questions that bereaved families may have. 11. The Welsh Government may wish to consider the applicability of the recommendations made within this report to other maternity and neonatal services.	

		On next steps, DC commented on: • The importance of the Board's acknowledgement of harm, acceptance of the responsibility to take action and recognition of the need to improve, to rebuild trust and confidence, with every contact counting. Apologising appropriately was always the right thing to do, recognising that families experiencing trauma may well need more than one conversation. • The report included examples of the type of poor care and experience that should never feature in a compassionate service. • The IR team welcomed the commitment to continue the conversation, with the self-referral midwife and psychological support remaining in place to provide advice and support to families needing this. • KS would continue to work with SBUHB communication team to reset the approach to family and community engagement. Thanking DC for her comprehensive overview and instructive analysis, JW reflected on just how challenging the report was; she once again offered the Board's apologies to the women and families who had engaged in the IR process, and to everyone whose experience had fallen far short of the required standard. She welcomed the approach taken throughout the IR, namely, to take the information and evidence and use it to support learning and improve experience and outcomes. A learning conference schedule for November would focus on all the learning resulting from the IR, to support SBUHB maternity and neonatal services become the best that they could be. JW then invited questions and comments. NM welcomed the presentation; she reflected on her different experiences of three pregnancies, particularly over the COVID-19 period when pregnancy could be a lonely and isolating experience. She empathised with families who had shared their stories and was sorry for their pain. NW shared a recent account when bereaved parents had talked of their use of ear defenders to block out the distressing noise of babies crying. NW supported the need for a dedicated and sensitively located bereavement suite where parents could spend time with their child. SBUHB should work with families to achieve this. She asked (i) what the Board had done to ensure continued support for families and (ii) whether there was a plan in place to reassure pregnant women using the maternity services that the issued highlighted in the IR report would be resolved. Responding, DC acknowledged the distressing nature of the report; the Board's acknowledgement of the harm and distress experienced, along with	

		the commitment to act, meant that Board members had heard the voices raised during the IR process, and through the FLR. Commenting on bereavement facilities, LR confirmed that plans were under development, recognising that the current arrangements were not acceptable. A better located suite with full soundproofing would be much more appropriate for bereaved parents. On plans to reassure women using the maternity services, LR outlined the work underway to support staff and enable them to have informative and honest conversations with parents. RT provided contact information on a helpline established for those who had concerns. The helpline number was 01792 986709 and was available Monday – Friday from 8.30am to 5pm. In addition a specific email address was available for those who preferred to make contact in this way: sbu.maternityenquiries@wales.nhs.uk . The SBUHB website would publicise the details. ALF took personal responsibility for not being fully sighted on all the serious issues that the IR report had highlighted and she offered families her sincere apologies. ALF reflected on the shortcomings of the Putting Things Right process and the time-consuming nature of managing formal concerns; the disproportionate number of less experienced midwives meant the need for greater senior support and this, coupled with resource pressures, gave ALF cause for concern about meeting families' rightful expectations. DC had a different perspective: in her view, earlier and more compassionate interventions and less adversarial discussions could and should prevent issues from escalating and becoming more resource intensive. Although newly qualified midwives would require support for skills development, they should all be able to communicate compassionately. ALF acknowledged this point, clarifying that her earlier remarks had centred on the more complex cases involving serious harm. DC commented on the fact that, that whilst effective and compassionate communication was everyone's business, some hospitals had introduced dedicated staff, who worked proactively to identify concerns at an early stage and to provide speedy redress. RO expressed her thanks for the detailed and thorough report; she too had found it challenging to read the parts detailing family experiences. RO expressed concerns about 'Board to Ward' assurance, and the need to ensure that the Board received relevant information and issues of concern. She also flagged the section in the report on the impact of deprivation and asked what more SBUHB could do at a population health level to address this.	

		On 'Board to Ward' assurance, DC drew attention to recent developments in England that could assist; dashboards had a role and value but were mechanistic data collections and DC emphasised family experiences as being key in capturing the impacts of failure, even in small numbers. KS recommended a wider and deeper engagement plan and welcomed the Board's clear commitment to developing this approach. The Board would benefit from a more varied engagement methodology, seeking to engage families and communities across the Swansea Bay area. His work with families had indicated their preference for more a focused and specific outreach approach; they were unlikely to respond to formal meeting requests. On population health, DC noted that, whilst pregnancy care required a key but small amount of time for families, population health programmes could cover longer timeframes. Targeted actions in partnership with Public Health Wales (PHW), focused on topics including substance and alcohol misuse, and reaching out to vulnerable and hard to reach groups, would be a positive development. JW confirmed that she had remitted the section of the report on population health matters to the Population Health Committee for consideration and advice to the Board, **Action: SS/GR** JW thanked DC and KS for responding to questions and comments, she then invited LR to introduce the paper setting out the immediate and planned responses to the IR report, through a comprehensive Improvement Plan. LR welcomed the intention to engage more effectively with families and was pleased to report on progress to date, acknowledging fully that SBUHB was at an early stage in the improvement journey. She advised the meeting that: • The MEWS system was in place Singleton Hospital and would roll out across the organisation as soon as possible. • The Triage process had improved, with plans under development for a 24/7 single point of access dedicated triage point, staffed by experienced and trained midwives. • There was now daily contact between the maternity unit and multidisciplinary teams. • Complaints and incidents had transferred to her portfolio, with a clear understanding of the need for meaningful engagement and deep listening. The planned review of the Putting Things Right process offered opportunities to consider organisational wide responses to incidents and complaints. • The planned all Wales learning event in the Autumn.	

		• Progress on debriefs, with recognition of more to do. LR extended her thanks to DC for the report; having the lead executive role for maternity services was a privilege for LR and she would use the report to drive improvements for the future. JW thanked LR and invited questions: NZ had found the report a difficult read and it had triggered personal experience; she thanked all families for their preparedness to revisit their trauma. This was a matter of fundamental importance for the Board, and specifically for Independent Members. NZ reflected on the deeper issues of culture and behaviour identified in the report that reflected weaknesses in wider organisational systems. She welcomed the Board's commitment to driving improvement, recognising the need to identify barriers and to understand what a good service looked like. Responding, LR agreed that cultural change underpinned all the planned improvement work. She and TR were working together to explore how best to deliver an open culture that supported staff in speaking out and delivered compassionate care. TR added detail on the introduction of a 'cultural heat map' designed to capture organisation wide information, using both soft and hard metrics, to identify areas in need of support. TR also commented on the forthcoming leadership and management development programmes. These would include modules on culture change. JW advised that Workforce and Organisational Development Committee (WODC) would oversee the impact of these programmes. **Action: RO/TR** JC added her thanks to DC and KS and apologised unreservedly for the Board's lack of sufficient oversight in previous years, as this had precluded earlier identification of the key issues highlighted in the IR report. She outlined the reset of the Quality and Safety Committee (QSC), underway currently, and committed to applying its scrutiny role to best effect, with clear visibility from' Board to Ward'. JC and LR were working together to redesign the style and content of QSC reports, to capture quality and safety issues at all levels across the organisation. QSC meetings would move beyond the receipt of quantitative data, to include qualitative analyses of themes and the interrogation of data against the key Board/Committee level indicators. JC and LR would ensure that QSC operated in line with a robust governance framework. On Governance, DC referred to the detailed information in the report and the challenge of delivering a robust approach to Governance across a number of Committees. JW confirmed that she, together with Committee	

		chairs and lead Executives, would hold a workshop in the autumn to design a robust process. **Action: JW/HL** AH commented on the broad programme of work underway on the Corporate Governance Framework, to specify greater clarity on roles and responsibilities at all levels in the organisation. Data storage in different areas across the organisation was a risk, as it generated a silo approach to data analysis, rather than a corporate one. The daily dashboard now available gave the Executive Team more visibility for executives, and this now needed to capture and signal those matters that require urgent attention. DC reinforced the risks associated with individual Committees focussing on different perspectives, when there was a need for collective mitigation of a whole risk. She welcomed the intention to hold a workshop to address this. Responding to NZ point about what good looked like, LR cited examples across the UK and confirmed the intention to research these and take the learning for the Improvement Plan. JW then asked MH, Chair of Llais, to comment; in doing so, she reminded the Board of the recent Llais report, and the inclusion of the key themes from that in the IR report. MH welcomed the invitation to the Board meeting and the opportunity to listen to the report findings. MH emphasised that Llais was not a regulator and was independent of government and the NHS; its role was to listen and engage. He welcomed both the IR report and the FLR, published the pervious day. MH also acknowledged the pain and hurt families had experienced over the years and the importance of the Board listening to their voices. MH also welcomed the clear apology to women and families and acknowledgment that SBUHB had got things badly wrong; the IR report reaffirmed systematic failures over the years and he reflected on how painful that must be for those women and families who had experienced a traumatic event. MH stressed the need to work with women and families and support them; he welcomed the focus on improving compassionate care. Llais would challenge the Board to move from aspirational statements to clear organisational change and improvement, utilising engagement as an ongoing process rather than ‘one time’ action. MH gave a commitment from Llais to work with the Board and to support all involved; anyone giving birth in Wales had a fundamental right to access safe and compassionate maternity care.	

		JW thanked MH for his comments and welcomed the offer from Llais of ongoing support for all those involved in the next steps. She was deeply appreciative of that offer, one that SBUHB welcomed. JW then invited AH to summarise the discussions and make the closing remarks at the end of a hard and emotional meeting. AH empathised with those women and families whose experiences had formed part of the Family Led Review, the Llais report and the IR report. Reliving those experiences would have triggered strong emotions and AH thanked them all. She also felt for the staff involved, as this was also a challenging time for them. AH added her heartfelt apologies, her commitment to delivering the improvements needed to secure kind, compassionate care that reflected good practice. The final report was comprehensive, with good quality data to build upon, and a seminal reference point for the Improvement Plan. The population health improvement journey was equally important; the Board needed a more in-depth understanding of the population and the communities that went beyond the analysis available to date. AH referenced the fact that more women from highly deprived communities gave birth in Swansea than in many other parts of the UK and the Board had to understand the implications of this. Whilst the focus of the launch was appropriately on families, AH also recognised that staff wanted to come to work and deliver compassionate care; they needed the right culture and environment to do so and the Improvement Plan would address both. AH confirmed that the September 2025 Board meeting would include an agenda item on the Improvement Plan, and the progress with resetting the approach to family and community engagement, as advised by KS AH then thanked DC, KS and the whole IR team for their robust and objective report, and for setting out clear recommendations that would enable SBUHB to deliver sustainable improvements. Finally, AH advised that, during the course of the meeting, the Cabinet Secretary had published a statement, escalating SBUHB maternity and neonatal services to the level of 'targeted intervention'. This was one level above that of 'enhanced monitoring'. JW thanked all those whose contributions had informed three hard-hitting, robust and sobering reports. The Board had listened to all those who had found the courage to relive traumatic experiences and JW assured them that their voices would count from now on. The Board:	

		• **Received** and fully accepted the report, findings and recommendations of the Independent Review. • **Apologised unreservedly** to all women and families whose care has fallen well below the expected standard. • **Took assurance** from the initial actions put in place and the arrangements to scope a comprehensive Improvement Plan. • **Took assurance** from the ongoing independent oversight arrangements. • **Agreed** to receive a further report at the September Board. • **Thanked** the Chair and members of the Independent Review Team for their comprehensive and rigorous report. JW then invited any member of the public to ask any questions or to make any comments. One observer, who had experienced a traumatic experience, was pleased that the HB had made an unreserved apology, something many parents had wanted for a long time. The observer finally felt listed to and believed; they hoped that the commendations set out in the reports would herald the beginning of real change.	
September 2025	6.4 Perinatal Committee Report	JW extended a warm welcome to KG and SP to the meeting and invited LJ to provide an update. LJ referred to the earlier discussion as part of the QSC report and drew attention to: • The role of the Perinatal Committee, established to provide assurance on maternity and neonatal services, and to oversee the Independent Review Recommendations, as progressed by the Perinatal Steering Group. • The actions underway on two of the immediate recommendations on an ITU/neonatal unit SOP and remote radiology reporting. • The single point of access maternity triage service, scheduled for March 2026, dependent on recruitment. • The implementation of the all-Wales MEWS and foetal surveillance training. • In-house sourcing of project management support, with strong interest in the opportunity. • High compliance on training. • PADR compliance at 83%, with mandated training also on track at over 85%.	Board September 2025 - Swansea Bay University Health Board

		• Earlier reference to the urgent recruitment for a neonatal consultant. • No current negative flags on quality and safety. • A positive inspection from Healthcare Inspectorate Wales (HIW), with completion and closure of ten of the fourteen actions. • Improvement in surgical site infection rates following targeted intervention. • HIV rates comparative to those across the UK. • A pilot site for the NHS questionnaire running at 46%, with a rapid response to the points raised. JW thanked LJ for the update; she confirmed that the Board would receive the full Improvement Plan at its November meeting. The report to that meeting would also include details on the role of the Independent Oversight Panel. KG thanked the Board for its support and for acknowledging the progress made to date. ML welcomed the positivity in the report and the improvements made. KG confirmed that staff welcomed feedback and were keen to share their experiences. NM also welcomed the report; given that the single point of access triage service was not scheduled until March 2026, she sought detail on the interim arrangements. KG confirmed that a nationally recognised triage system for maternity services was in place, enabling women to access the service through a single pathway. JW referred to the remote radiology reporting issue and invited RE to comment; he began by outlining the features of a paediatric radiology service, with a full-time reporting system. It had taken longer to resolve and identify a suitable solution to meet three different, challenging requirements: (i) paediatric radiology (ii) neonatal radiology and (iii) cranial ultrasounds for neonates; SBUHB had only one paediatric radiologist and scaling up the service would be extremely challenging; work was underway to scope the possibility of commissioning the service from a third-party provider. The position on cranial ultrasounds was different, and RE was exploring a network arrangement, to support the local neonatologists. ALF reflected on RE's points and asked whether NHS England had any Centres of Excellence, with specialist radiologists who might provide assistance. RE advised that he was exploring all options. AH reported on a recent visit by the new CMO to the Maternity Unit in Singleton; Isabel Oliver had met with staff to discuss the improvements	

		made already and those in train. Staff had identified access to radiology reporting as one of the most challenging of the recommendations to implement and the CMO had agreed to support a wider conversation on support for small specialist services. In the meantime, SBUHB would focus on an interim solution. ALF also asked about the recruitment of Band 5 midwives, whether the financial position had an impact on this and if the triage system could proceed without new staff. KG advised that ten newly qualified midwives were due to join the service shortly on a 22.5 hours per week contract; experience indicated that natural attrition rates would see an increase in those hours within a short timescale. KG confirmed that the launch of the triage system depended on approval of the business case under development currently. JW asked KG to provide Board members with a briefing on the triage service outside the meeting. **Action: KG** JW invited AH to provide a summary of a recent meeting held with the Swansea Maternity Support Group; this provided an important opportunity to meet with families, some of whom had engaged with the Independent Review process, and to listen to their stories and concerns. AH again offered sincere apologies for the harm caused and the trauma that some parents and families had experienced; the Family Led Review, the Llais report and the Independent Review report had all documented their experiences. She reflected on the need to support individuals and families who were pursuing complaints or legal action, to ensure that they understood the different processes in place and could navigate their way through them. AH emphasised the importance of saying sorry if a pregnancy and/or birthing experience was sub optimal, as the lack of an apology had a profound effect. Ken Sutton, the Independent Review Engagement Lead, was now working with SBUHB to build on family and community engagement arrangements. She and JW hoped that the Swansea Bay Maternity Support Group would form one of the ‘sounding boards’ in the new engagement model. AH then referred to the forthcoming Learning Conference on 19 November. This would include the opportunity for families to share their learning. She concluded by outlining the plans in place for independent oversight of the Improvement Plan through the Oversight Panel, to be joined by a WG Observer. The Board:	

		• **ACKNOWLEDGED** the plans in place to secure project management support to develop and monitor the Improvement Plan. • **REVIEWED** progress against the two immediate actions from the Independent Review report (relating to Intensive care/Neonatal Unit Standard Operating Procedure and remote radiology reporting). • Took **ASSURANCE** from the contents of the report, namely that: the Maternity Workforce was Birthrate Plus Compliant, Personal Annual Development Reviews and Mandatory training compliance were on track; the Perinatal Service currently had no Negative Outliers; the full establishment in respect of maternity services in the Obstetric Unit. • **ACCEPTED** that the launch of the Single Point of Access Maternity Triage service in March 2026 would depend on the recruitment of newly qualified Midwifes. • **ACCEPTED** the recruitment of the 0.8 WTE vacancy for a Neonatal Consultant from September 2025, to maintain British Association of Perinatal Medicine standards.	
November 2025	Perinatal Committee Report	**Perinatal Committee Report** *The Board took this Agenda item after 3.1 before returning to Agenda item 3.2* Introducing this item, LR provided some background and context, including the setting up of Perinatal Committee in June 2025, with a remit to (i) consider and respond to key quality standards and outcomes on an ongoing basis, (ii) oversee the Improvement Programme, and (iii) respond to the Maternity Independent Review recommendations. LR then provided a summary of the key indicators and data: • 290 women had given birth in September, delivering 294 babies. • The total caesarean section rate was 40%, with an elective rate of 16.2%. • The mortality and morbidity rates, with ten stillbirths reported in the last reporting period. The UK stillbirth rate was 2.94%, that for Wales was 3.63%, and the SBUHB rate was 1.29%. Every loss was traumatic for the	Board November 2025 - Swansea Bay University Health Board

		families involved and LR confirmed the strengthening of bereavement support service, with work underway to strengthen neonatal support as well. All staff had received bereavement training. • Seven neonatal deaths had occurred between January and September, two of which had been MBBRACE reportable. • There were six reported cases of hypoxic ischaemic encephalopathy HIE, with a good outcome for all babies on discharge. • Recruitment into midwifery posts meant that SBUHB was now temporarily over-established on newly qualified midwives; this would rebalance with the recruitment to band 6 posts. Neonatal services had also over recruited to band 5 posts, and all staff had successfully completed specialist training. • Recruitment to all neonatal consultant posts. • Positive outlier status in three areas of the neonatal national audit, with no negative outlier indicators. There were four areas either below or above the Welsh average, all subject to close scrutiny, with action plans in place. • The measurement and reporting of all delays in induction of labour; of the 78 inductions in September, six were subject to delay. Clinical prioritisation was in place with daily oversight and a clinical' huddle'; digital data capture was also under exploration. • SBUHB participation in an NHS core questionnaire; this sought views from pregnant women at five stages during pregnancy. Families with concerns, or who reported a negative experience, would have the opportunity to discuss these further. Turning to the Independent Review (IR) recommendations, LR reported that: • A unified triage system was in place; this resulted from the implementation of the Birmingham Symptom specific Obstetric Triage System (BSOTS) assessment model in November 2024. Dedicated midwifery assessment was in place but not currently operating on a 24/7 basis. The full	

		24/7 service was scheduled for March 2026 and would be the first in Wales. • The time taken to triage ranged from 15 to 30 minutes. There had been no triage-related incidents in the last 12 months. • On two site working, the ITU and perinatal teams had strengthened communication arrangements; however, the split site position remained a risk. • A successful workshop with the Oversight Panel on 17 November had proved very instructive, with the identification of four key themes, under which to progress the 10 Independent Review recommendations, each with an executive lead. The first Improvement Programme Board meeting was scheduled for December, with a regular reporting mechanism in place. JW thanked LR for her summary and then invited questions: RO found the update very positive, welcoming the level of detail and the use of benchmarking; she took assurance from this approach. On triage, RO queried the possible acceleration of the full 24/7 service. Responding, LR advised this would require both investment and recruitment; it would be the first 24/7 service in Wales and would require lead-in time. NZ also asked about triage and wondered whether March 2026 was achievable, given resource and recruitment challenges. She welcomed the Improvement Programme and the positioning of the 10 recommendations in the wider context, with QSC level oversight on behalf of the Board On the issue of investment, JW reminded the Board that it could not invest money that it did not have and that the Executive would be working through the means of offsetting the cost against other savings. This was necessary, as the Oversight Panel had identified this recommendation as the highest risk, requiring urgent action. **Action: AH** KL referred to the data collected for the various indicators and asked about possible disaggregation to site level. LR confirmed that this was possible. Commenting on the silver award from BLISS to the neonatal team, a first in Wales, AH complimented the team on its drive for continuous improvement, as was the cases across the whole maternity and service. The whole Board joined with AH in extending warmest congratulations to the team. The Board:	

		• **WELCOMED** the project management support in place, to develop and then form part of the oversight of the Improvement Plan, in response to the Independent Review.
		• **SUPPORTED** the Perinatal Improvement Programme Executive Board, beginning in December 2025.
		• **ACKNOWLEDGED** that the Perinatal Committee would meet monthly, and would review all key metrics for perinatal services.
		• **WELCOMED** the feedback from the Learning Event held on 19/11/25, with over 200 attendees from across Wales and UK.
		• **AGREED TO RECEIVE** the final Perinatal Improvement Plan at the January 2026 Board meeting, now forming part of a wider Improvement Programme.
		• **TOOK ASSURANCE** from the following:
		  • The fact that the Perinatal Service currently had no negative outliers; the four areas either below or above the Welsh average were subject to close scrutiny.
		  • The MBBRACE process ensured the reporting of all stillbirths as required.
		  • The reporting of 6 cases of HIE to MBBRACE in this period.
		• **ACCEPTED THE ALERT** in respect of the 24/7 triage service, due to launch in March 2026. The Board would consider further advice on this as part of the 2026/27 Annual Plan deliberations.
		
		Oversight Panel Report
		JW welcomed DC, joining the meeting via Teams, to present the first Oversight Panel (the Panel) Report.
		DC drew attention to:
		• The role of the Panel over the coming year and its key objectives; this included the critical friend role, alongside the assurance role being discharged by Ann Gow, as the Cabinet Secretary's observer.
		• The range of expertise on the Panel; could assist SBUHB on its improvement journey. Panel members had all offered their input to support the improvement work.	

		• The meeting between Panel members and SBUHB service leaders to provide feedback on the draft Improvement Plan; the main area of concern related to the reliance on the Executive Director of Nursing for delivery of the whole improvement programme. A more distributive approach to accountability and leadership across the executive team would have benefits and would ensure the critical safety factors that required explicit medical leadership were addressed. • The welcome progress on triage; the key risk was the need for a single pathway for all pregnant women, together with the mitigations put in place in the interim. • The constructive workshop held on 17 November; this could form the basis of an ongoing approach. • An executive led Programme Board would help SBUHB in its response to the report and also with public engagement more broadly. • The positive feedback from the Conference on 18 November was a good beginning for an ongoing conversation between SBUHB and the public. Frontline staff should be included in any follow up work. DC concluded by sharing sad news. Professor Tim Draycott, who had provided a video message for the Conference, had passed away suddenly. She would liaise with RT on the timing for the issue of the message, as a tribute to Professor Draycott; JW and the whole Board asked DC to convey their sincere condolences to his family. Responding to the update, JC advised that she had attended the conference and had found it very informative. She asked about embedding the learning from this point, including the knowledge gained from the experts who spoke on the day and the salutary experiences of families and service users. DC referred to the discussion at the Conference on restorative justice, families wanted to know how things would change; over 1000 families had engaged with the Independent Review and the overwhelming message was one of willingness to work with SBUHB on service improvement. Those who had shared their experiences were clear that current adversarial, investigative processes could compound harm rather than ease distress and add to their trauma. She recommended using more family story feedback at a local/operational level, as well as at Board level. ALF recalled one story at the Conference about a new mother not knowing how or where to seek help. DC advised that there was no single point of	

		access to such help and suggested that SBUHB could usefully research good practice. NZ had also attended the Conference and had found the debate on how to engage with communities really powerful; the opportunities extended beyond maternity and neonatal care, to all services. JW thanked DC for the feedback, for sharing the Panel's objectives, the offer of a 'critical friend' approach and comments on the first draft of the Improvement Plan. She looked forward to further quarterly updates from the Panel. The Board **WELCOMED** the first of a series of quarterly Oversight Panel reports and **THANKED** the Oversight Panel for their offer of ongoing advice and expertise.	
January 2026	Perinatal Committee Report	The Perinatal Committee Report JW welcomed CG and FG to the Board, at what was a milestone in progress made since the publication of the Independent Oversight Panel report - *SBUHB Independent Review of Maternity and Neonatal Services*- in July 2025; she congratulated KG, FG and everyone involved on the production of both the Perinatal Committee report and the Improvement Plan, acknowledging the challenges associated with doing so. JW then invited LR to introduce the two items, beginning with the Perinatal Committee report. LR drew attention to the range of measures taken, including the setting up of the Programme Board and the development of the Board Champion roles. She reported that, in November 2025, 238 women had given birth with 249 babies delivered, an indication of the scale of the service. LR then drew the Board's attention to the range of indicators in the Perinatal Committee report: • The rising caesarean section rate: this was in line with a national trend across the UK. In some areas, caesarean section rates had overtaken vaginal births; a specific group would provide comprehensive and balanced information to support individual and family decision making. • The infection rates for maternity~~,~~ were generated mostly from community samples. The service continued to monitor 28-day infection rates even though the reporting requirement was now 14 days. • The learning from mortality and morbidity data, recognising the two-year reporting lag.	Board January 2026 - Swansea Bay University Health Board

		• The rates of stillbirths: all were reported and investigated and were in line with the UK average. • The inclusion of Neonatal death data. • Rates of hypoxic ischaemic encephalopathy (HIE): these were reported on a 12-month rolling basis, with a 45% decrease seen since a peak in April 2024. These reports generated significant learning. • The use of the Birmingham specific triage system: this provided the ability to monitor responses, and more than four thousand women had used this system over a year. • The inclusion of third- and fourth-degree tears: each case was investigated and the position in SBUHB was lower than England. • The reduction in post-partum haemorrhage rates. • The changes and improvements in Incident Reporting. • The current position on patient feedback and experience, with an engagement midwife now in place to focus, specifically on this. • The current position on induction of labour and any delays, with no harm reported for some time. • The key workforce metrics, demonstrating successful recruitment to key posts. • The implementation of infection prevention audits. • The findings of the perinatal audit process. • The detail in the Risk Register outline. • The detail in the Quality Improvement methodology included. • The number of national awards. JW thanked LR for her detailed presentation of the statistics and invited questions: JC commented on the difference in the breadth of information provided in the report, when contrasted with that available a year ago: the Quality and Safety Committee (QSC) now had a wealth of data to analyse. JC paid tribute to everyone involved in reaching this point and thanked LR for introducing benchmarking, given the beneficial impact of this. JC went on to raise the safety and quality implications of two-site working and the interface with unscheduled care (UC), confirming that QSC would consider this.	

		PP welcomed the range of data and insight now available, welcoming the fact that there were no negative outliners in terms of elements of care. She asked about discussions with WG on the de-escalation requirements. LR outlined the discussions to date and the data shared with WG; she advised that WG was waiting for the outcome of the *all-Wales Maternity Assessment* expected on 9 February 2026. JW also referred to the role of the Oversight Panel in scrutinising the Improvement Plan and that of the Observer, Professor Ann Gow, appointed by the Cabinet Secretary to the Panel; there were, therefore, a number of external parties providing advice to the Cabinet Secretary on de-escalation. (Professor Gow's first report to the Cabinet Secretary, on 11 December 2025, is attached as Annex 1 to the minutes). RO and NZ were both impressed by the data sources now available and expressed an interest in understanding more about the increase in caesarean section rates. KG explained that there were a number of reasons associated with this, including: fear of repeated birth trauma; the demographic and socioeconomic factors; and choice. KG reported that choice played a large part and professionals needed to encourage pregnant women and families to ask questions and understand their options and choices. LR emphasised the importance of choice and supporting women to make the choice that was right for them. NZ followed up with a question on the lessons identified and implemented to date, particularly around triage; KG confirmed that the learning was significant and that she would return to this in the following item on the Improvement Plan. AH welcomed the additional real time data available for operational management, trend analysis and planning. A Quality Improvement (QI) approach was vital; she was pleased to see the focus on QI in the report. NM endorsed this, indicating that the report was easy to read with a wealth of information. She asked about the impact of the bereavement midwife and the training of other midwives to cover her absence; NM also sought an update on the refurbishment of the bereavement room. KG outlined the training for all staff on bereavement care with an annual update for everyone on compassionate care and the loss of a baby. She was pleased to confirm significant progress in the development of the bereavement room; this would make such a big difference to families at such a devastating time. TO asked about the workforce implications of choice, with the potential need for more staff, given more invasive delivery options, and the mitigation of workforce-related risks. TO went on to suggest Equality Impact Assessments (EIAs) to support the perinatal QI programmes.	

		LR confirmed that every health board had to respond to parental decisions on choice and work was underway to assess the different levels of care necessary to meet that choice, citing access to anaesthesiology as an example; she also assured the Board on the inclusion of EIAs. JW thanked everyone for a very rich and informative report and the detailed questioning on the content. The Board: • **ACCEPTED** the advice, assurance and alerts set out in the report. This followed on from the role of the Perinatal Committee, as reported to QSC, in overseeing all aspects of quality, safety, patient engagement and experience outcomes (business as usual). • **ACKNOWLEDGED** that the Perinatal Committee met monthly, **REVIEWED** all key metrics for perinatal services, on behalf of the full Board, and **INTENDED** to review the content of the report regularly. <u>The Perinatal Improvement Plan</u> LR expressed her pleasure in bringing the Improvement Plan (IP) to the Board; she framed the work underway through the grouping of the ten recommendations set out in the *SBUHB Independent Review of Maternity and Neonatal Services* (July 2025) report into four workstreams: • Clinical safety. • Family engagement. • Workforce leadership and education. • Governance and assurance. LR advised that the IP not only addressed the recommendations. but set out to transform the service, so that it provided safe, reliable and compassionate care for every family. The work was underpinned by strengthened governance processes, with AH chairing the Perinatal Improvement Programme Board and important roles for the two Board Perinatal Champions. She summarised the progress made across the workstreams, as set out in the IP. LR indicated that the Board would receive worked examples on two of the recommendations: triage and two-site working, now interpreted as 'care pathways for all pregnant women in non-maternity settings'. She then invited KG to talk about triage. KG provided a scenario to demonstrate the safety and consistency of the new urgent access telephone triage pathway. (The script is attached to the minutes as Annex 2 to the minutes). In response to a question from JW around	

		auditing of the new triage system, KG confirmed that such auditing was already in place and that QSC would receive regular reports. RE then talked through the implications of care pathways for all pregnant women in non-maternity settings. This extended the concept of two-site working to multiple-site working, with a Standard Operating Procedure developed jointly with relevant clinical staff. RE also took the opportunity to explain the concept of a safety huddle and to outline the use of Maternity Early Warning System (MEWS) scores, launched in July 2025. The system was now in use in all acute areas in Morriston Hospital, with training provided for all staff. RE then provided examples to show how the additional actions taken supported the care of pregnant women. (A copy of the script is attached as Annex 3 to the minutes). He assured the Board that the new approach was systematic and provided immediate escalation. JW thanked both KG and RE for their worked examples, aimed at providing the Board with systematic assurance; the Board had to assure itself that both triage and the procedure for multi-site management of pregnant women were consistent and reliable and not dependent on individual practice. Both KG and RE were clear that consistent and reliable systems were in place; there was recognition across Wales of the importance of this, with SBUHB being one of two health board teams selected to trial a Quality Management System Learning and Development Programme. JW thanked KG and RE for their informative examples and explanations; she then invited comments and questions. JC referenced two-site working and welcomed the additional work undertaken to make procedures applicable for pregnant women across all care settings. She asked about the capture of learning on a consistent basis, and any measure in place to capture harm; she sought further detail on the comparison between the models in SBUHB and Liverpool. Responding, AH outlined how the Perinatal Improvement Programme Board exercised oversight of actions and impact, to ensure consistent application of the improvement programme.	

		RO asked about extending the learning to the Neath Port Talbot Birthing Centre and about the financial implications of the IP; she sought confirmation of the inclusion of these in the 2026/27 Annual Plan. LR confirmed that all staff were involved in learning processes, with formal rotation of the Neath Port Talbot Birthing Centre staff under current consideration. She confirmed that the current resource envelope included much of the current work to date, rather than requiring new funding. There would be future resource implications, and these would be subject to further debate at Executive level; she also highlighted the links to population health and the risks associated with deprivation. Population health actions could assist as part of the comprehensive model of care. JW concluded the discussion by thanking all involved and asking LR and KG to thank everyone who contributed to producing the IP. The Board looked forward to the next progress update, to be provided quarterly. Denise Chaffer, chair of the Independent Oversight Panel, would join the Board at its March 2026 meeting, to provide feedback on the IP. On the Perinatal Improvement Plan, the Board: • **TOOK ASSURANCE:** • that the organisation had a comprehensive plan to address the recommendations of the *SBUHB Independent Review of Maternity and Neonatal Services*, *Family Led Review of Maternity Services*, and *"Having a baby in Neath Port Talbot and Swansea Report"* Llais Report, and any actions required after the imminent publication of the All-Wales Assessment of Perinatal Services. • On progress made since the publication of the Independent Review in July 2025, on key safety actions. • On the robust governance and assurance structure underpinning ~~of~~ the Perinatal Improvement Plan. • **TOOK COGNISANCE OF**: • The strong national steer that there would be an All-Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment. The Perinatal Improvement Plan Executive Programme Board had agreed to pause development of a standalone SBUHB model, pending publication of the Assessment (due end of January 2026). February 2026	

		would see the introduction of the mitigating action- a single point of contact triage phoneline. A single telephone entry point would direct women to the appropriate department, based on their needs, and would be subject to ongoing safety and quality monitoring. • The outsourcing of paediatric radiology provision as an interim mitigation measure. There was a need for a potential regional solution to provide long term assurance and sustainability of service provision. • **APPROVED** in principle the Perinatal Improvement Plan (including worked example scripts) for submission to the Independent Oversight Panel for scrutiny.	
March 2026	Perinatal Committee Report	**Perinatal Committee Report** Introducing the Perinatal Committee Report, LR recognised that every woman and their family deserved high quality compassionate care; this was the case for most families. There were times when things did not happen as they should; when that happened the impacts on the woman and the whole family were profound. LR reiterated her commitment to listening, learning and improving so every family received the care they deserved. The Perinatal Committee meeting members remained passionate about improving and getting things right. She drew attention to: • 257 births in January, with 261 babies born. • The gradual rise in caesarean sections, in line with the position across the UK. • Recent improvements in infection rates, with training provided for community midwives on wound care and work with GPs to recognise the early detection signs of infection; this included specific work with black ethnic minority women to recognise signs of infection. • In the sad event of any baby death, SBUHB applied the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) process. There were no stillbirths in January 2026; SBUHB rates remained in line with those for other health boards and there was a detailed review of each case. • A thematic review of 2025 cases had helped to strengthen growth surveillance, with follow up for non-attendance. The review had led to a change in the process to a three-stage approach, including a letter and follow up in person.	Board March 2026 - Swansea Bay University Health Board

		• Hypoxic ischaemic encephalopathy (HIE) instances were rare but had devastating impacts. The rolling 12 month moderate to severe HIE rate had fallen from 3.32 in 2024 to 1.24 per thousand births currently. • In January 2026, over 500 women were triaged; 93% of these within 15 minutes. There were no adverse incidents reported for the 7% where triage took longer. • Perinatal tears and post-partum haemorrhage rates; these mirrored national benchmarking levels. • The monitoring of Intensive Therapy Unit (ITU) admissions, with daily processes in place to review any pregnant woman receiving care outside the main maternity unit. There had been one birth in the ED in February 2026, this had been well managed. • Substantial progress in closing incidents and complaints, with low numbers still remaining, improving compliance with Duty of Candour requirements. • Listening to families and their experiences was hugely important, with waiting times at antenatal clinics identified as an issue. The pathway was subject to redesign as a result of the engagement. • The re-modelling of staffing on postnatal wards to reflect the higher cesarean section rate and the impacts of this on staffing. • The significant difference made by the patient experience midwife in engaging with hard to reach communities; specific work was underway on the recognition of father and partner experiences. • The challenges around neonatal medical staffing, managed by the team to avoid any impact on the service. • Good mandatory training compliance, with targeted intervention aimed at areas where compliance had dropped. • No negative outlier positions against national comparators for SBUHB; constant scrutiny and oversight was in place. • The Improvement programme; this was proceeding well, overseen by QSC and then to the Board. JW thanked LR for the comprehensive update and for the progress made. She invited questions: RO asked how the Birthing Centre was developing and the percentage of births that took place there. LR advised that in the first year of opening the Birthing Centre had 197 births and supported 75 home births. Year two to date had seen 85 births with 35 home births supported. AH advised that the Dashboard provided this information; she sought assurance over the	

		maintenance of staff skills, given that, for most weeks, the number of weekly births was in single digits, running at approximately 14 per month. Numbers had never reached the level expected when the Board approved the reintroduction of the service. LR confirmed that she would commission a report for the Perinatal Committee and then to QSC. **Action: LR** MJ responded to JCs earlier query regarding cardiotachography; he confirmed that a work around was in place to address the loss of connectivity. TO asked about caesarean sections and the underlying reasons for this; she also asked about the availability of demographic data. LR confirmed that she would provide the data. GR commented on the risk factors associated with decisions to request a caesarean birth; dashboard and weight management data would assist in this. JC wanted to put on record her thanks to RK and LR for their work on maternity services and in briefing QSC. Reflecting on earlier comments, she asked about the learning and themes emerging about the women's experiences forum that met monthly. LR confirmed this was available; she would provide a report to QSC on a quarterly basis. **Action: LR** The Board: • **WAS ADVISED** that: The Perinatal Improvement Plan Executive Programme Board was well established and would continue to monitor the Improvement Plan, in response to the Independent Review, all-Wales Self-Assessment, and other improvement actions. The Perinatal Committee would continue to meet monthly and review all key metrics. • **WAS ASSURED THAT:** The Perinatal Service had no elements of care that would flag as a Negative Outlier. Any stillbirths or neonatal deaths were reported sensitively through the MBRRACE process, to support learning and improve future care. • **WAS ALERTED TO:** The strong steer nationally that an All-Wales maternity triage service would follow, as a recommendation from the All-Wales Perinatal Assessment.	

		The Perinatal Improvement Plan Executive Programme Board had agreed to pause development of a standalone SBUHB model pending publication of the Assessment (due end of Jan 2026). The achievement of mitigating action to provide a single point of contact triage on 3 March 2026. Calls were directed to a single telephone entry point, with women then directed to the appropriate department based on their needs. This process would deliver one central call centre for maternity triage. **Oversight Panel** ('the Panel') **Report** DC referred to the paper provided, and highlighted: • The Panel consideration of the latest version of the Improvement Plan and commentary on the Perinatal Committee Report. • The Panel's view that there was some more work to do on the Improvement Plan; this would also provide an opportunity to incorporate the outputs of the all-Wales Maternity Assessment Review. • The need for more work on (i) the strategic framing of family involvement and experiences, (ii) the overall increase in the Caesarean section rate, happening across Wales and also England, and (iii) more detail on two-site working. The Panel recognised the significant work already undertaken on obstetric admissions to the intensive care unit; the challenges of multi-site working needed a little more work. DC commented on the one case of a woman giving birth in the ED, and the opportunities to learn from that for those giving birth on a site without access to obstetric services. • The Panel's overall view was that the reports had significantly improved, providing the Board with information on actions and progress with the Improvement Plan; DC also recognised that the Improvement Plan would by its nature be an iterative report. • The Panel's decision to follow on from the Conference held in November 2025 by holding another full day event for frontline staff. This was scheduled for 18 June 2026 and would also include a clinical visit. • The Panel would also share an assurance framework, against which SBUHB could track progress, once the Panel stepped down. JW thanked DC for her helpful update and asked about the timeline for finalising the Improvement Plan.	

		Responding, DC suggested that the Panel could supply further detail in time for the Board to approve the Improvement Plan in final form at its May 2026 meeting. The Plan would evolve further, using the outcomes of the all-Wales Assessment as an example of the need to continually update it in line with developments. DC suggested a separate progress report as a means of tracking progress and supplying the up to date position. LR extended her thanks to DC and the Panel for their advice and guidance. She outlined the different ways in which the Executive team, the QSC, and the Board would receive updates. JC welcomed the focus on partners and fathers, together with the opportunity to further develop the engagement theme. She asked about the implementation of computerised cardiotachography in February 2026. LR confirmed that the system was operational with no issues identified over recent weeks; she would check the position and confirm this. **Action: LR** JW asked DC to expand on the Panel's intention to stand down in the autumn. DC confirmed this and advised that the Panel was very positive about the management and oversight infrastructure that the Board had instituted; this provided the Panel with confidence that they could stand down as soon as an assurance framework was in place to track ongoing progress. JW extended the Board's thanks to DC and the Panel for their expert advice and guidance; she also thanked JC and QSC members for their rigorous oversight. The Board: • **RECEIVED** and **ACCEPTED** the update from the Chair of the Independent Review of Maternity and Neonatal Services Oversight Panel. • **AGREED** to receive the final Improvement Plan at the May 2026 Board meeting, alongside the assurance framework to track ongoing progress.	
May 2026	4.6 Perinatal Services • Perinatal Committee Report	Awaiting minutes	28-May 2026 - Swansea Bay University Health Board