Workstream 1: Clinical Critical Safety Actions

What does this theme encompass:	**Immediate safety recommendations from the Ind Review including:** **•Triage** **•Induction of labour prioritisation** **•Two site working, risk mitigation, early warning scores** **•Neonatal radiology** **•Multidisciplinary training** **•Investigations/learning/actions** **•Senior level supervision/oversight** **•Escalation/raising clinical concerns**
Executive Accountable Lead: Executive Medical Director (Richard Evans)	
Operational Lead: Associate Service Group Medical Director CYP&W (Sujoy Banerjee)	
Group members: Deputy Executive Medical Director (Raj Krishnan) Neonatal Clinical Lead (Jo Webb) Clinical Director for Perinatal & Gynaecology Services (Madhu Dey) Head of Midwifery (Cath Harris) Obstetric Clinical Lead (Najiya Ali) Clinical Lead Anaesthetist – Singleton Site (Eleanor Lewis)	**Dates of Steering Group Meetings for 2026:** 6 January, 14:30 – 15:30 3 March, 14:00 – 15:00 7 May, 09:00 – 10:00 7 July, 14:30 – 15:30 1 September, 14:30 – 15:30 3 November, 14:30 – 15:30

Themes	Overarching Action	Action ref	Action Detail	Owner	Timescales	Outcomes/Metrics (unless otherwise described, Reporting and monitoring is via Perinatal Committee)	Progress to date (inc date of update)
		1.1.1	Women and families have reported inconsistent access and variable experiences when contacting maternity triage services. Delays or incorrect triage advice pose risks to maternal safety and clinical outcomes. Implementation of a fully staffed triaged system, medical and midwifery staffing aligning with BSOTS methodology, aligning with guidance from the Royal College of Obstetrician and Gynaecologists and the Royal College of Midwives. The single point of access telephone number will support women to be directed to the appropriate departments based on thier enquiry, ensuring that all women requiring triage services will be directed to Maternity Triage as the single triage service.	Head of Midwifery	Sep-26	% of women seen within primary target of 15 mins; secondary target of 30 mins; outcomes for those who are not seen in target time and those who leave before being triaged. % of dropped calls from the single point of access telephone number to Maternity Triage. Reported to Perinatal Committee on a monthly basis, and through Quality [illegible]	**Dec 2025:** Revised business case presentation at the Planning and Finance Assurance Subgroup. **Jan 2026:** Funding agreement for roles need for service still unconfirmed; recruitment not underway. Revised business case will be presented toPlanning and Finance Assurance Group on 21 Jan 26, which, if approved, will enable next steps. Escalate to Perinatal Improvement Exec Programme Board. **January 2026:** Business casefor new service being finalised. Current service able to provide appropriate cover between 12pm and 5pm, which is the evidenced highest acuity point. However, this can be impacted by staff availability. Requires further funding for 24/7 service. On-call service provided from 5pm by clinical staff who are also covering other areas, such as labour ward. Any incidents are logged on Datix and monthly audits undertaken of targets to identify and address any concerns. **January 2026:** There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment **20 Jan 2026:** Perinatal Improvement Plan Executive Programme Board agreed to pause development of a standalone SBUHB model pending publication of the All-Wales Perinatal Self-Assessment (due end of Jan 2026).
		1.1.2	Single point of access telephone number for women and families in Swansea Bay while full service is established. Realignment of current arrangement to ensure the temporary telephone number will provide a menu of options for women so they can be directed to the appropriate departments based on thier enquiry, ensuring that all women requiring triage services will be directed to Maternity Triage as the single triage service.	Head of Midwifery	Feb-26		**March 2025: T**he development work including scripts for a single telephone number as the point of access for women and families to Swansea Bay Maternity Services completed. The service were advised to pause this work as this did not provide assurances for the implementation of a Maternity Triage Servcie which was aligned to the BSOTS model and RCOG best practice guaiance. **Jan 2026:** CH has shared script for options on single line with key stakeholders for feedback, these have been Welsh Translated and sent for recording. **Jan 2026:** Single telphone number request and communications plan for staff, women and wider stakeholders in development. Planned go live date Feb 2026.

Maternity Triage	1.1 Establish a dedicated 24/7 telephone triage service within maternity services to improve patient safety, streamline clinical workflows and enhance patient satisfaction	1.1.3	Establishment of a Single telephone access as outlined in model approved by SBUHB Board in July 2025. Establish effectiveness of BSOTS by benchmarking against standards (completed by Independent Midwife Nov 2025) and audit the quality of the telephone contacts with women and % of dropped calls.	Head of Midwifery	Sep-26	and Safety Committee. Development of risk to be added to local risk register to monitor delays in BSOTS guidance for appropriate escalation.	**Nov 2024:** Implementation of BSOTS within SBUHB has ensured a more standardised approach to risk assessment, prioritisation and escalation of women who attend the maternity triage department. In September 2025, 493 women were seen in triage; 98% were seen within the standard triage time. **Sept 2025**: Development of a business case to enable a full front door Maternity Traige service with a dedicated core set of midwives to provide a 24 hour telephone triage service seperate to the clinical care requirments of a midwifery triage team (already in place). The business case also includes the requirment of a middle grade medical workforce to escalate women with urgent needs to maintain safety and mitigate compounded risk of delays impacting clincal outcomes for women and babies. **Nov 2025:** Business case reveiwed and tested by Independant Obstetric Panel to provide assurances that the business case is robust and ariticulates the resource requirements to provide a safe, timely and effective Maternity Triage Service. **Nov 2025:** Independent Midwife assessment of Maternity Triage Service, benchmarked against RCOG guidance. Areas of non-compliance corolate to % recording of % dropped calls to triage, medical staffing and a seperate telephone traige line manded by Midwives 24 hours in an area away from clinical triage area of care. Reported to QSC and Board via the Perinatal Committee Report.
		1.1.4	Progress recruitment of staff (both midwifery and obstetrics) to provide robust maternity triage service as outlined in high level model approved in principle by SBUHB Board in July 2025. Improve the environment by ensuring that telephone triage is not co-located and is in an area that ensure privacy for triage calls.	Head of Midwifery / Clinical Director for Perinatal & Gynaecology Services	Sep-26	Staffing model fully established and trainined at service launch due date	**Nov 2024:** Implementation of BSOTS, additional clinical midwife funded to ensure compliance with BSOTS staffing requirements - 2 midwives available 24 hours to provide clinical tirage within the setting. Middle grade roster realignment to provide cover between the hours of 12pm - 5pm which is an interim measure to provide timely access to medical expetise when patient acuity increases as demonstrated by audited data. Ongoing BSOTS data reporting to ensure any breaches in reveiw time are cross referenced to any harm events reported as a result of delays. Board alerted via the Perinatal Committte report. **Dec 2025:** Revised business case presentation at the Planning and Finance Assurance Subgroup. **Jan 2026:** Business case amendments to enable funding for roles for service being finalised. Risk of slippage - posts yet to be approved through vacancy authorisation process; recruitment and training time will require 3-4 months from approval. **Jan 2026:** There has been a strong steer nationally that there will be an All Wales maternity triage service developed as a recommendation from the All-Wales Perinatal Assessment. **20 Jan 2026:** Perinatal Improvement Plan Executive Programme Board agreed to pause development of a standalone SBUHB model pending publication of the All-Wales Perinatal Self-Assessment (due end of Jan 2026).
abour (IOL) Prioritisation	1.2 Develop and implement a robust process for booking and prioritising women undergoing induction of labour	1.2.1	Development of a digital system for booking and prioritisation of induction of labour	Consultant Women's Health / Deputy Head of Midwifery	Apr-26	proportion of IOL booked digitally;	**Jan 2026:** Full implementation will happen with Badgernet at the end of March 2026. Dedicate training will be provided as part of implementation.
		1.2.2	Development of standardised referal form template to ensure consistent information detailing Risk Assessment for every induction of labour. Develop a bookings process which includes triage of planned inductions of labour ensuring those with the highest level of risk are priortised at the start of the working week. Implement multidisciplinary safety huddle which focus on review of booked IOL, check prioritisation category, assess staffing and bed capacity, identify risks or delays agree escalation actions if required.	Consultant Women's Health / Deputy Head of Midwifery	Apr-26	Proportion of IOL where risk assessment undertaken; proportion of IOLs undertaken as per risk assessment time frame; number of postponement or cancellation of IOL; number of adverse outcomes where IOL was undertaken out of sync with risk assessment or were delayed. Reported to Perinatal Committee on a monthly basis, and through Quality and Safety Committee. Locally reviewed through Maternity Services Risk Register (reviewed monthly and reported through Service's Quality, Safety and Risk Forum). Data to be periodically reviewed by peer unit to benchmarking performance.	**April 2024:** Multi-disciplinary hand overs twice per day. Planned activity including Induction of Labour and on-going Induction of labour are discussed at these hand overs, risk assessed and prioritisation with staggered admissions of new inductions of labour timetabled. **Sep 2025**: Delayed or re-scheduled Induction of Labour DATIX reported and reviewed by the Perinatal Committee Report for monitoring and or escaltion to Board. **Jan 2026:** IOL SOP sourced from another HB in England and being used as a template to adapt and develop an SBUHB bespoke version. **Jan 2026**: Working group to develop digital booking form on Badgernet. Currently using a paper-diary which consultants use to priotise and this is communicated at MDT meetings twice a day.

Section	Objective	Ref	Action	Lead	Timescale	Measure of success	Progress
Induction Of La[bour]		1.2.3	Capacity and and demand for caesearean birth impacting on the Induction of Labour pathway with access to one only fully functioning theare on labour ward - review and consider the opportunity to move planned caesearean birth off Labour Ward and away form acute labour needs of women. 1. Consider the impact of a rising caesearean section birth rate which is impacting on flow through labour ward leading to delays in induction of labour and ongoing care planning. 2. Explore establishment of elective obstetrics theatre to avoid delay of continuation of IOL (RCOG Labour Ward Solution Good Practice No.10 2010 - a guide to obstetric theates equirements standards). / (Providing Quality Care for Women - A framework for Maternity Service Standards RCOG (20085) 7.2.3.5 There must be separate provision of staffing and resources to enable elective work to run independently of emergency work, in particular to prevent delays to both emergency and elective procedures and provision of analgesia in labour)	Clinical Director for Perinatal & Gynaecology Services / Directorate Manager Perinatal & Gynae	Business Case approval and submission to WG by Health Board by the end of 2026	None at present - to be discussed after approval	**Jan 2024:** Elective Obstetric cases (by risk selection - lowest risk cases due to the location of Neonatal Services should a baby require resuscitation) x2 lists per week in main theatres Singleton. High Risk cases require planned birth on the Labour Ward creating risk for labouring women requiring an emergency section during planned births. Second obstetric thatre available and would be utilised in an emergency and main theatre staffing and capacity to run two theatres simultaneously. Planned caesarean births rising with current rate of category 4 (elective and 3 (at a time that suits the safety of the service) being 18.5% and 5.8%. Overall Cesearean birth rate 43.2% of all births in month and a landscapes of 28% inducation of labour rate. **March 2025:** Capacity and demand concerns escalated for service consideration. **Date 2025:** Commenced exploratory discussions and location of dedicated elective obstetric theatres. **Jan 2026:** Scoping exercise underway.
Two-site working	**Ensure robust SOP is in place for admissions to ITU during the pregnancy pathway**	1.3.1	Develop and implement Standard Operating Procedure for women in a non-maternity setting. (All-Wales Maternity Early Warning Score (MEWS) Standard Operational Procedure Morriston Emergency Department). SOP to include coproduction of pre-emptive care planning and delivery of perinatal care in patients with complex medical issues. Also to include formalised Terms of Reference for Perinatal MDT and escalation process for high risk, complex care.	Associate Service Group Medical Director CYP&W / CD of Midwifery / Clinical Director for Perinatal & Gynaecology Services / Consultant Neonatologist	Apr-26	Exception report of non-compliance with SOP for pregnant women requiring care in non-maternity settings. Monitored via local risk register in Service; and reporting by exception to Perinatal Committee on monthly basis.	**July 2025:** Development of SOP between Maternity and ITU Team - COMPLETED **July 2025:** ITU admissions metrics included in the Periantal Committee report - COMPLETED **July 2025:** Perinatal services embedded into the Health Board 3 daily safety huddles and provide sit rep which is reported across the SBUHB - COMPLETED **July 2025:** Implementation of the national Maternity Early Warning Score (MEWS) - tool to support and identify the detoriating woman with appropraite escalation for medical reveiw and treatment - COMPLETED. **July 2025:** MDT implemented for any admissions in Morriston to support safe and effective care planning **Sept 2025:** SOP ratified by both Maternity a NPTSSG and Intensive Care MSG, signed off and ratified via Intrapartum Forum and noted at the service group's Quality and Safety Group -- ACTION COMPLETED **Jan 2026:** SOP to be reviewed and considered as a Health Board wide SOP for any woman admitted to any part of the service pregnant requiring MDT are planning and support - In Progress **Jan 2026:** Health Board consideration of single site working and location of Periantal Service for future servcie modelling and future proofing of servcies. **Jan 2026:** Implementation of MEWS in other key areas, Gynaecology (COMPLETED), ED (COMPLETED with ongoing audit). (RAILLS to provide update to dates) **NB** existing Neonatal SOPs in place include Framework Plan for the Management of Possible Delivery of Pre-Term Infant At Morriston Hospital, Swansea; the neonatal guidelines on Sharepoint for 'newborn resuscitation' and 'Early Care of very Premature Babies'. In addition, for transport, the Standard Operating Procedures of CHANTS (Cymru inter-Hospital Acute Neonatal Transfer Service).
		1.3.2	Benchmarking and site visit exercise with other hospitals with two site settings to ensure our process is robust.		Apr-26	Testing of process through teaching and education exercises	**Jan 2026:** Only one site identified currently i.e. Liverpool. Clincal Leads to make contact and get SOP in action for comparison, and arrange visit to
[Neona]tal Radiology	**Ensure the provision of full time paediatric radiology , including a mechanism for reviewing cranial USS in neonates.**	1.4.1	Provision of suitable coverage either through local recruitment or SLA provision with another Health Board, funding agreement needs confirmation. Increased specialist resource is required to ensure in and out of hours coverage for paediatric radiology, particularly for neonatal cranial ultrasound. Radiology images are currently interpreted by neonatal medical staff. As an interim solution, the service plans to outsource image reporting. Despite repeated efforts, the service has been unable to recruit additional paediatric specialist radiologists. While appointing another paediatric radiologist remains a requirement for the health board, the fragility of paediatric radiology services across Wales means that alternative long term reporting options will be considered, including the development of a regional model.	Executive Medical Director	Dec-26	Images to be reviewed in line with BAPM guidelines; specifically timely reporting of diagnostic imaging, with compliance to agreed departmental turnaround times stratified by clinical priority (e.g., urgent, priority, routine). Exception reporting to SDG Quality & Safety Forum	**Jan 2026:** proposal need to agree specific requirements and way forward. **Jan 2026:** Discussions to commence at regional forum

Theme	Objective	Ref	Action	Lead	Date	Measure	Progress
Neona		1.4.2	Interim action: agree interim outsourcing arrangement for working hours currently not staffed and OOH provision, including funding.	Executive Medical Director	Feb-26	Images to be reviewed in line with BAPM guidelines; specifically timely reporting of diagnostic imaging, with compliance to agreed departmental turnaround times stratified by clinical priority (e.g., urgent, priority, routine). Exception reporting to SDG Quality & Safety Forum	**Jan 2026:** Approval for provision of outsourcing of service on interim basis agreed by PIP Executive Programme Board 20.01.26.
Multidisciplinary training	**Ensure standardisation of training and usage of safety measures and tools linked to maternity and neonatal outcomes**	1.5.1	Introduce the current maternity-specific early warning score tool to all areas where pregnant women are cared for. Ensure standardisation of training and usage of safety measures and tools linked to maternity and neonatal. Specifically: 1. Implementation of MEWS and NEWTT2 in Perinatal Services 2. Consider wider servcie implementation of MEWS where pregnant women access health servcies across the Health Board. 3. Consider wider service implementation of NEWTT2 where new-born babies may require care outside of perinatal servcies. 4. Provide ongoing assurances via sudit that the tools are being used and evidence of escalation when scores indicate medical review required and achieved.	Associate Service Group Medical Director CYP&W / CD of Midwifery / Clinical Director for Perinatal & Gynaecology Services / Consultant Neonatologist	COMPLETE	Consistent usage of systems, including MEWS, NEWTTS, PROMPT, IFS and NLS. Training compliance reported to Perinatal Committee on monthly basis.	**March 2025:** Implementation of NEWTT2 across Perinatal services - COMPLETED **July 2025:** included in the Matron monthly audit on AMAT for long term sustainablility of assurances. **July 2025: I**mplementation of the national Maternity Early Warning Score (MEWS) - tool to support and identify the detoriating woman with appropraite escalation for medical reveiw and treatment - COMPLETED. **July 2025:** PROMPT training includes the new MEWS to align scenario based training to the current tools to monitor the deterioration of women. **Oct 2025:** Audit undertaken to test compliance withteh new tool to detect deterioration of the new-born - COMPLETED **Jan 2026:** Implementation of MEWS in other key areas, Gynaecology (COMPLETED), ED (COMPLETED). Recognition of Acute Deterioration And Resuscitation (RADAR) to provide update to dates)
Investigations, learning and actions	**Ensure improved timeliness and quality of dissemination/cascading of learning relating to investigations/concerns to operational teams**	1.6.1	Communication following serious adverse events must be prioritised, and appropriate multidisciplinary reviews conducted within reasonable timescales, and in line with MBRRACE-UK and serious incident review guidance. 1. Establish whether existing timescales are in place for safety critical updates, and if not, establish standards of 24/48 hours, including records of dissemination. 2. Ensure non safety critical learning is cascaded via monthly "Risky Business" newsletter, including records of dissemination. 3. Engage with service governance processes and monitoring to assess performance.	Matron Neonates, Quality, Safety & Risk Nurse Specialist Neonates, Consultant Neonatologist (Arun Ramachandran), Consultant Obs & Gynae (Ellie Price), Interim Matron Maternity , Senior Advanced Neonatal Nurse Practitioner; Lead Midwife Quality Improvement Practitioner for Maternity Services	May-26	Learning to be formalised and documented via Clinical Audit Plans	**April 2023:** All National reportable incidents are incident reported and undergo a rapid review following first lining. First lining of incidents occurs daily Monday-Friday. All incidents are discussed in Maternity safety brief meeting Monday-Friday. All incidents identified as a NRI where care contributed to harm are reported and a strategy meeting is arranged following rapid review within 72 hours of first lining. All strategy reviews include executive chair, service group leads and PSIT for scrutiny. During the strategy meetings, make safe's are discussed, immediate actions, contact with the family and continued engagement plan and scope of investigation. All immediate actions and immediate make safe's are recorded and uploaded to the datix record for evidence in support for LFER. All incidents that are MBRRACE reportable are reported as NRI as identified as 'Must Reports'. These include notification to the PSIT and progress of incidents discussed in two weekly meetings with the Head of Assurance and NPTSSG Quality and Governance leads. All NRIs including must reports are escalated through Perinatal assurance to Perinatal comittee for ward to board learning.
evel supervision / oversight	**Delivery of consistent care with senior clinical staff oversight in line with policy mandates**	1.7.1	To oversee the care of sick babies Senior Consultant presence needs to be clearly articulated within the clinical records. Develop and audit cycle and key indicators to provide assurance which include care planning underpinning decision making.	Clinical Director for Perinatal & Gynaecology Services / Consultant Neonatologist	COMPLETE	Interim measure: Benchmarking against BAPM guidelines already achieved. Additional measures to be embedded via Badgenet implementation (April 26), inc presence at deliveries < 28 weeks gestation, presence at complicated CS or rotational forceps deliveries. Reported to Perinatal Committee on a monthly basis, including workforce metrics.	**Nov 2025:** RCOG and BAPM Senior Consultant presence: In Maternity, Senior Clinical Staff (specialty grade / consultant) is on site for 22.5 hours a day with back up non-resident consultant on call during out of hours. The neonatal unit has already implemented an interim 13 hour, seven day, on-site consultant rota from April 2025 in line with British Association of Perinatal Medicine (BAPM) guidelines, facilitated by the appointment of an additional locum consultant. These are currently in place. COMPLETED
		1.7.2	Senior clinician staff must have a mandatory presence in operative vaginal births, including rotational births, forceps or assisted breech births and complex caeserean births must be attended by senior clinical staff. Develop an audit cycle and key indicators to provide assurance which include births by birth mode. An audit will be undertaken using the TOMS system to review senior obstetric presence for: 1) operative vaginal births, including rotational forceps deliveries in theatre and 2) complex caesarean sections over a six-month period.	Associate Service Group Medical Director CYP&W / CD of Midwifery / Clinical Director for Perinatal & Gynaecology Services	COMPLETE		**Nov 2025:** RCOG and BAPM Senior clinician presence In Maternity, Senior Clinical Staff (specialty grade / consultant) is on site for 22.5 hours a day with back up non-resident consultant on call during out of hours. The neonatal unit has already implemented an interim 13 hour, seven day, on-site consultant rota from April 2025 in line with British Association of Perinatal Medicine (BAPM) guidelines, facilitated by the appointment of an additional locum consultant. These are currently in place. COMPLETED **Jan 2026:** TOMS - data colletion will commence from February 2026. The audit findings will be presented at the Intrapartum Forum and recorded within the Q&S meeting. Any identified concerns will be escalated through the Perinatal Committee as appropriate.

Senior l[illegible]		1.7.3	Consider revision of rota in labour ward and neonatal ward to ensure full coverage at BAPM recommendations	Associate Service Group Medical Director CYP&W / CD of Midwifery / Clinical Director for Perinatal & Gynaecology Services / Consultant Neonatologist	COMPLETE	Ongoing Benchmarking against BAPM guidelines. Reported to Perinatal Committee on a monthly basis, including workforce metrics.	**Sep 2025:** Benchmarking againast the RCOG and BAPM standards of staffing ratios to provide senior oversight and support - COMPLETE
Escalating / raising of clinical concerns	**Ensure an embedded culture that enables staff to feel safe and able to raise and report clinical concerns**	1.8.1	Strategic culture development of a Multidisciplinary team leadership department programme designed and initially supported by Professor Michael West.	Workstream 3 (HR BP / Associate Service Group Director)	Apr-26	Triple AAA reporting through Perinatal Committee / Guardians Service / Reporting via audits and visits / staff survey / Trade Unions / Workforce Heatmap	**Jan 2026:** 6 sessions run between Feb 2026 and April 2026.

Workstream 2: Family Engagement

What does this theme encompass:	Listening and acting to ensure mothers and families at the heart of our decision making and service delivery, with a focus including: • Response to harm, including "Harmed Patient Pathway" • Decision making and consent • Investigations and learning • Birth trauma • Culture/behaviours, cultural awareness and diversity • Continuous improvement

Executive Accountable Lead: Executive Director of Nursing and Patient Experience (Elizabeth Rix)

Operational Lead: Head of Midwifery (Cath Harris)

Group members:	**Dates of Steering Group Meetings for 2026:**
Assistant Director of Insight, Commuications and Engagement (Jo Abbot-Davies) Head of Engagement (Nicola O'Sullivan) Patient Experience Midwife (Hannah Gardener) Quality, Safety & Risk Nurse Specialist - Neonates (Leanne Richards) Lead Midwife Quality Improvement Practitioner for Maternity Services (Kate Bannister) Service Manager Neonatology (Sam Jones) Consultant Midwife (Vic Owens) Kate Burke Diverse Outreach Workers team Patient Feedback Team Public Health Team	6 January, 13:00-14:00 4 March, 10:00-11:00 5 May, 13:00-14:00 7 July, 11:00-12:00 9 September, 10:00-11:00 3 November, 11:00-12:00

Themes	Overarching Action	Action ref	Action Detail (inc ref no)	Owner	Timescales	Outcomes/Metrics	Progress to date (inc date of update)
Map sources of data, evidence and intelligence in relation to engagement	**2.1. Produce a map of all sources of data, evidence and intelligence on our patients and their families experiences when accessing perinatal services, including: oListening in real time oListening when things have gone wrong oListening/engaging on future improvements**	2.1.1	Map sources of feedback received through internal SBUHB channels, including QR code feedback, patient comments, feedback received to staff, feedback of staff.	Head of Midwifery	Complete	Captured in report to Perinatal Committee	
		2.1.2	Map external sources of feedback, including patient experience, complaints, incident reviews, reviews by external regulators	Patient Feedback Team	Quarterly from Apr 26	Single report of data produced with thematic learnings and insights	**Jan 26:** Constituent parts produced, work to be done to develop unified report
		2.1.3	Map post-independent review engagement undertaken by Oversight Panel Family Engagement Lead, ensuring feedback and actions are captured.	Ken Sutton / Assistant Director of Insight, Commuications and Engagement	Quarterly	Ensure any feedback is incorporated into overall engagement	**Jan 2026:** mapped engagement completed to date and regular catch ups diarised.
		2.1.4	Overlay mapped data with engagement intelligence to ensure robust and accurate reflection of feedback.	Assistant Director of Insight, Commuications and Engagement / Head of Engagement	Jul-26	Single integrated report collating all info in lines 7-10 received, considered and conclusions and actions reported to Perinatal Committee	**Jan 26:** Indentified component parts, need to agree single forum for benchmarking prior to feeding back to Perinatal Committee.
		2.1.5	Review role and scope of the Maternity and Neonatal Voices Partnership in line with Llais guidance to ensure women and their families have robust presentation via the Partnership	Assistant Director of Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery	Apr-26	Updated scope and terms of reference (as appropriate)	**Jan 26**: initial discussions with Llais commenced with a view to agreeing the way forwards.
		2.1.6	Develop a Perinatal Engagement Strategy, triangulating existing intelligence data. Strategy to include development of a "Harmed Patient Pathway".	Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery / ED of Corporate Nursing & Patient Experience	Jun-26	Improved feedback and indicators from patients, trainees, HEIW site visits, Quality indicators, perinatal KPIs	**Jan 26:** scoping work underway on Harmed Patient Pathway

Theme	Objective	Ref	Action	Lead	Timescale	Measure of success	Update
Stakeholder map	**2.2 Finalise stakeholder mapping to ensure comprehensive plan for ongoing inclusive engagement: (a) specifically on MatNeo by the Service Group (b) specifically on MatNeo by DICE and other corporate teams (c) as part of the Health Board's 'always on' engagement process facilitated by DICE which generates feedback on any aspect of the Health Board's activities**	2.2.1	Utilising NPT and Swansea CVSs, finalise stakeholder map including record of engagement to date and stakeholder categorisation.	Assistant Director of Insight, Commuications and Engagement / Head of Engagement	Apr-26	All groups and mechanisms mapped and collated in engagement programme	**Jan 26:** commissioning undertaken; work commenced and expected to be completed by end of financial year
		2.2.2	Utilise Diverse Outreach Workers team to ensure capture of seldom heard voices and people who can't speak up.	Assistant Director of Insight, Commuications and Engagement / Head of Engagement	in place, quarterly touchpoints	Ensure any feedback is incorporated into overall engagement	**Jan 26:** scope of work agreed and ongoing programme of developing relationships
		2.2.3	Develop engagement plan/framework for Perinatal team to support listening opportunities, feedback loops and to embed learning across the service based on our patient data, evidence and intelligence	Assistant Director of Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery	Quarterly from Apr 26	Single report of data produced with thematic learnings and insights	**Jan 26:** Indentified component parts, need to agree single forum for benchmarking prior to feeding back to Perinatal Committee.
		2.2.4	Develop Women's Network sounding board, with feeder sounding boards specific to Perinatal Services	Assistant Director of Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery	Apr-26	All groups and mechanisms mapped into Women's Network and feeder sounding boards	**April 26:** first gathering / engagement activity held
Evolve Perinatal Improvement Plan using engagement feedback	**2.3 Develop mechanisms to review the Perinatal Improvement Plan against feedback from stakeholders**	2.3.1	Using the service specific engagement approach, ensure families' feedback is captured; and ensure that we test and evolve the Improvement Plan based on this. Also take advantage of any 'always on'engagement feedback relevant to the agenda.	Assistant Director of Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery	Quarterly	Improved feedback and indicators from patients, trainees, HEIW site visits, Quality indicators, perinatal KPIs	**From April 26**
		2.3.2	Pilot engagement approach as part of the maternity triage service changes that are in progress (link to Workstream 1)	Assistant Director of Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery	Feb-26	Improved feedback and indicators from patients, trainees, HEIW site visits, Quality indicators, perinatal KPIs, including triage metrics	**Feb 26**: Gather feedback from mothers of their experience of the new maternity triage service changes once they are implemented. Timing dependent on new triage implementation date.
Develop an always on engagement approach	**2.4 Develop and adapt the organisation's "always on" approach to engagement to specific perinatal model, ensuring robust two-way feedback cycle**	2.4.1	Evaluate pilot approach used for triage and amend and apply to an "always on" engagement approach	Assistant Director of Insight, Commuications and Engagement / Head of	Mar-26	Single report of data produced with thematic learnings and insights	**April 26:** first gathering / engagement activity held
		2.4.2	Facilitate meaningful engagement opportunities for the Specialist Women's Experience Midwife, building on knowledge gleaned from the 'always on' engagement approach, particularly targeting hard to reach and disadvantaged groups	Assistant Director of Insight, Communications and Engagement / Specialist Women's Experience Midwife	Quarterly from April 26	Feedback shared as and when generated with the Head of Midwifery and Assistant Director of Insight, Communications and Engagement to enable the listen and act approach	
Popuation Health	**2.5 Translate feedback into actions, focusing on Population Health improvements.**	2.5.1	Coproduction of messaging relating to perinatal outcomes, e.g. smoking cessation, weight management, mapping against deprivation and worst served/at highest risk communities.	Public Health team	Mar-26		
		2.5.2	Coproduction of comms plan relating to Public Health team proposal for maternal weight management service	Assistant Director of Insight, Commuications and Engagement / Head of Engagement / Head of Midwifery / Public Health Team	Feb-26		**Jan 2026:** Public Health team leading on development of (business case for maternal weight management service.

Workstream 3: Workforce / leadership / education and training

What does this theme encompass:	**Leadership & Culture - Compassionate leadership/culture / behaviours** **Cultural awareness for minority groups** **Trauma informed care**
Executive Accountable Lead: Executive Director of Workforce & OD (Tina Ricketts)	
Operational Lead: Associate Service Group Director, Children, Young People and Women's Services (Michelle Mason-Gawne)	

Group members:	**Dates of Steering Group Meetings for 2026:**
HR Business Partner (Jess Harris) Directorate Manager for Perinatal Services and Gynaecology Services (Abi Morris) Clinical Director for Perinatal & Gynaecology Services (Madhu Dey) Head of Midwifery (Cath Harris) Clinical Education Team TBC Psychology Service (Vanessa Hammond / Matt Lewis) Others to be coopted as needed	6 January, 11:00-12:00 3 February, 09:00-10:00 3 March, 10:00-11:00 2 April, 13:00-14:00 5 May, 10:30-11:30 2 June, 13:00-14:00 8 July, 13:00-14:00 5 August, 10:00-11:00 8 September, 16:00-17:00 3 November, 15:00-16:00 8 December, 13:00-14:00

Themes	Overarching Action	Action ref	Action Detail	Owner	Timescales	Watch Metrics	Progress to date
Leadership and Culture	**3.1 Ensure that our Perinatal Services have compassionate leadership, culture and behaviours**	3.1.1	Develop and deliver a Multidisciplinary Team Development Programme co-designed and initially supported by Professor Michael West. This is a pilot programme aligned to national roll out led by HEIW. (Appendix 1). Pilot programme to be attended by senior leadership of Perinatal Services.	Associate Service Group Director /Associate Service Group Medical Director CYP&W	Apr-26	Workforce KPIs via the Heatmap, staff feedback, feedback from Guardian service and Trade Unions, and staff survey results.	**Jan 2026:** 6 sessions run between Feb 2026 and April 2026.
		3.1.2	Evaluation of this pilot programme will measure success prior to wider roll-out both locally and nationally. This evaluation will inform the next phases of cascade from April 2026 as appropriate. Continued collaboration with HEIW and the national programme will also enable scalability as required, along with adapted internal modalities and versions of delivery i.e. digital options.	HEIW/SBU HR BP and OD Lead	Quarter 1		Jan 2026: To commence in April 2026.
		3.1.3	Development of a Perinatal Staff experience, wellbeing and retention plan (SEWR) to cover all staff groups of Perinatal Services.	Directorate Manager, Clinical Director & Head of Midwifery - Perinatal & Gynae	Apr-26		**Jan 2026:** In development, meeting on 15.1.26 to scope out next steps with Perinatal Leadership Team. SEWR themes are aligned with key compentent themes of the improvement plan with specific reference to this workstream.
Cultural awareness for minority groups	**3.2 Develop appropriate education and training linked to feedback from patients, families and groups representing patients from minority groups and communities who are less heard.**	3.2.1	Ensure mandatory training relating to Equality, Diversity & Human Rights is completed across the service.	Directorate Manager, Clinical Director & Head of Midwifery - Perinatal & Gynae	Monthly reporting	Training Compliance Data	**Jan 2026:** Monthly monitoring and reporting in place via Perinatal Assurance Group.
		3.2.2	Ensure staff are aware of and are able to access translation services for women and families who require them.	Directorate Manager, Clinical Director & Head of Midwifery - Perinatal & Gynae	Mar-26	Patient feedback, site visit feedback, staff feedback, quality and safety data, ER cases, Chaplaincy, Datix, feedback from Trade Unions.	
Education and Training	**3.3 Develop a documented Education and Training Plan for Perinatal Services**	3.3.1	Develop a documented plan for education and training for Perinatal Training (also outlined in the draft Perinatal SEWR Plan) that includes four pillars of Mandatory & Statutory Training; Essential to Role; CPD; Personal Development Offer. To cover all staff groups of Perinatal Services.	Directorate Manager, Clinical Director & Head of Midwifery - Perinatal & Gynae	Jun-26	Training Compliance Data	**Jan 2026:** Further discussion at meeting on 15.1.26 to scope out next steps with Perinatal Leadership Team. Make use of PDN to support pulling this document together.
ormed		3.4.1	Explore service requirements associated with an enhance provision of psychology-led therapeutic services.	Vanessa Hammond / Matt Lewis / Kathy Greaves (TBC)	Service changes to be in place by Sep 2026		**Jan 2026:** scoping underway
		3.4.2	Undertake recruitment exercise related to business case	Directorate Manager	Sep-26	Pending business case progress	

Trauma Info Care	**3.4 Establishment of a psychology-led therapeutic perinatal service**	3.4.3	Agree training programme and delivery schedule in trauma informed care to be rolled out to all staff groups of Perinatal Services.	Directorate Manager / Clinical Director & Head of Midwifery / Associate Service Group Medical Director CYP&W	Sep-26	% of staff attending training; Workforce KPIs via the Heatmap, Patient feedback, site visit feedback, staff feedback, quality and safety data, ER cases, Chaplaincy, Datix, feedback from Trade Unions	

Workstream 4: Governance

What does this theme encompass:	**Immediate safety recommendations from the Ind Review including:** **• Board reporting** **• Complaints/incidents/claims processes** **• Structures and processes** **• Clinical guidelines** **• External relationships and reporting**

Executive Accountable Lead: Director of Corporate Governance (Hazel Lloyd)

Operational Lead: Clinical Director of Midwifery (Kathy Greaves)

Group members:	**Dates of Steering Group Meetings for 2026:**
Head of Assurance and Regulation (Rebecca Nix) Head of Corporate Governance (Kate Morgan) Senior Advanced Neonatal Nurse Practitioner (Gemma Davies) Lead Midwife Quality Improvement Practitioner for Maternity Services (Kate Bannister)	6 January, 14:30 – 15:30 5 February, 14:30-15:30 4 March, 14:00-15:00 1 April, 10:00-11:00 6 May, 14:00-15:00 3 June, 11:00-12:00 8 July, 14:00-15:00 5 August, 13:00-14:00 4 September, 13:00-14:00 7 October, 14:00-15:00 4 November, 13:00-14:00 2 December, 14:00-15:00

Themes	Overarching Action	Action ref	Action Detail (inc ref no)	Owner	Timescales	Outcomes/Metrics (unless otherwise described, Reporting and monitoring is via Perinatal Committee)	Progress to date (inc date of update)
Governance for Perinatal Improvement Programme	**4.1 Agree & define governance for Perinatal Improvement Programme (PIP).**	4.1.1	Establishment and clear definition of governance structure for PIP, underpinned by appropriate documentation to ensure robust and timely reporting to Board (Appendix 2).	Exec Director Nursing & Patient Experience / Director of Corporate Governance / Programme Lead	COMPLETE	Establishment and clear definition of governance structure for PIP, underpinned by appropriate documentation to ensure robust and timely reporting to Board. Clear reporting framework for key indicators of maternal and neonatal outcomes and performance indicators, including critical events, time limited pathways, MBBRACE, NNAP, and workforce KPIs based on heatmap.	**Dec 2025:** Perinatal Improvement Plan Executive Programme Board established, chaired by CEO. Meeting on bimonthly basis, with monthly update papers submitted to SBU Management Board. Formal reporting to Board also uses existing processes and follow governance framework to Alert, Assure and Advise. Terms of Reference also make provision to include recommendations to be actioned from All-Wales Self Assessment on Maternity and Neonatal Services once published.
		4.1.2	Clarify "business as usual" governance to provide assurance on perinatal performance sitting outside of Perinatal Improvement Plan reporting mechanisms.	Exec Director Nursing & Patient Experience / Director of Corporate Governance / Programme Lead	COMPLETE	Clear definition of governance structure for operational "business as usual", underpinned by appropriate documentation to ensure robust and timely reporting to Quality and Safety Committee. Clear reporting framework for key indicators of maternal and neonatal outcomes and performance indicators, including critical events, time limited pathways, MBBRACE, NNAP, and workforce KPIs based on heatmap.	**July 2025:** Perinatal Committee established, chaired by Exec Director of Nursing and Patient Experience. Reporting on a monthly basis on business as usual performance, including . Reporting into Q&S Committee. Underpinned at operational level by Perinatal Assurance Group. Formal reporting to Q&S follows governance framework to Alert, Assure and Advise.
		4.1.3	Ensure that there is a robust understanding from Ward to Board of the Governance process for the Perinatal Services - link into Perinatal Services Education and Training (Workstream 3) to build into induction process and in learning offers.	Senior Advanced Neonatal Nurse Practitioner / Lead Midwife Quality Improvement Practitioner for Maternity Services / Service Group leads	Jun-26	Training compliance data	

Benchmarking	**4.2 Benchmarking against other Health Boards of governance processes to seek out best practice and provide highest levels of assurance for SBUHB processes**	4.2.1	Undertake comparison exercise against other Health Boards to compare SBUHB perinatal governance arrangements, and highlight any gaps and or areas the organisation provides a higher level of assurance. Integrate learning into our processes.	Head of Corporate Governance	Mar-26	Comparison of arrangements and desktop testing to map any gaps in our arrangements	
Guidelines Group	**4.3 Establish Maternity and Neonatal Guidelines Group to ensure cyclical review, adoption and rollout of perinatal guidelines, with priority given to critical safety/national and NICE guidelines**	4.3.1	Establish Maternity and Neonatal Guidelines Group, underpinned by ToR and core membership, to ensure cyclical review, adoption and rollout of perinatal guidelines, with priority given to critical safety/national and NICE guidelines. Reporting through Perinatal Committee in line with "business as usual" governance arrangements. Ensure adminstrative activities are aligned with existing processes on WISDOM (mat) and COIN (Neonates) and develop a system for monitoring, tracking and reporting using AMaT.	Clinical Director of Midwifery / Senior Advanced Neonatal Nurse Practitioner / Lead Midwife Quality Improvement Practitioner for Maternity Services	Mar-26	Timely review of guidelines ensuring 100% of locally owned are reviewed, that national guidance is bechmarked adopted and embedded into services; workforce heatmap KPIs; auditable standards are included on the forward audit plan.	**Jan 2026:** terms of reference (Gudielines/Audit Forum) drafted,annual schedule for meetings in progress. Percentage of guidelines in date monitored via Forward Audit plan in draft. Workforce metrics embedded and presetened at Perinatal Committee. Current compliance across all guidelines sits at 88%, however, this is an aggregated figure that that includes local service guidelines, which are within the service's gift to manage, as well as wider Health Board policies and national policies that are beyond the control of the Perinatal Service teams.
Investigations, learning and actions	**4.4 Ensure improved timeliness and quality of dissemination/cascading of learning relating to investigations/concerns to operational teams**	4.4.1	The Board must ensure that, where there is a clear trigger for independence or external review, this is actioned; examples would be a very serious incident, serious birth injury, maternal death, or mortality review. The Board must ensure greater involvement of families in investigations. 1. Perinatal governace processes demonstrate triggers for independant reviews. 2. Perinatal governance processes demonstrate how the service engaged with families subject to a case review, provided feedback and disseminated learning across the service on completion of the reviews. 3. Perinatal services to demonstrate how immediate 'Make Safes' are ideintified and cascaded urgently at the time of identification. 4. Perinatal services and Health Board governance structure must demonstrate floor to Board and Board to floor reporting for assurance and escalation purposes.	Director of Corporate Governance	May-26	Requires adjustment to the governance process and policy	Maternity services have comissioned external reviews for all Maternal deaths since November 2024. All NRI where care was not considered contributory are escalated for external review for transparency and learning. At present, this is facilitated through expert independent clinicians and the service is absorbing the expenses for these reviews. At present, perinatal services have four external reviews outstanding. Where the service identified a BOD has occurred, the service is undertaking the review, with the acknowledgement experts will be instructed at redress / claim stage for causation to ensure reviews are timely for families. At present, external reviews are taking over 12 months to return, despite experts confirming timing during instruction. The perinatal service engages all families who undergo a HIE, Stillbirth, Neonatal death, Maternity death or incident triggering a DOC. All famillies have face to face meeting during admission and point of contact. All families recieve written confirmation and are provided with a questionnaire to be able to engage in the review process and ask questions. At present, the service is reviewing a SOP for continued engagement with families, to ensure families are kept informed of progress of review throughout investigation. All parental feedback is included within the review and addressed by the MDT. All Stillbirths, HIE, Neonatal deaths, Maternal deaths and incidents triggering DOC
		4.4.2	External input is critical in ensuring that learning from mortality reviews is maximised. Development of reciprocal arrangements with other UK networks to participate in case reviews would ensure a true 'fresh eyes' approach.	Director of Corporate Governance	May-26		At present, Perinatal services are comissioning external reviews through the legal team - instructing expert clinicans to provide an opinion. This has been costly and timely for the service.