Priority	Recommendations	Response	Action
1. Joined up national perinatal leadership to ensure consistency in strategic planning, quality and safety across Wales	**a. A National Perinatal Team** We recommend that national Clinical Directors or leads in obstetrics, neonatology, neonatal nursing and obstetric anaesthetics are appointed at varying levels of FTE. This will establish a multidisciplinary national perinatal senior clinical team to work together with the Chief Midwifery Officer to advise on and drive policy developments in the Welsh Government and hold Health Boards and other service-providers to account.	**Accept**	We will review the current clinical leadership team which includes the Chief Midwifery Officer in Welsh Government and the Obstetrician, Midwife and Neonatologist based in NHS P&I. A strengthened collective national oversight of perinatal services is needed, with the requisite authority and comprehensive understanding to drive continual improvement and nationally consistent standards of care and safety.
	i. A National Strategic Oversight Board This board should include all relevant national stakeholders with a remit for perinatal services (including but not limited to HIW, HEIW and the WRP), the national perinatal team and a service user representative. The aim of this group would be to achieve comprehensive oversight and shared accountability. The Board should be supported by two specialist subcommittees: one focused on frequent review and action on quality and critical safety signals, and a second overseeing health boards' delivery of the perinatal National Reportable Incident process and the dissemination of learning.	**Accept**	Welsh Government will establish a National Strategic Oversight Board with relevant membership and published terms of reference. The Board will be supported by a subcommittee which will focus on continual review of quality and safety using relevant data systems. A further subcommittee will be created to oversee the National Reportable Incident process and ensure timely dissemination of learning.

	ii. A National Women, Parents and Communities Maternity and Neonatal Group We recommend that the planned National Maternity and Neonatal Voices Panel also includes representatives from community advocacy organisations representing populations at increased risk of poorer experiences and outcomes in perinatal services, and that it elects a representative to sit on the national strategic oversight Board.	**Accept**	As part of the perinatal engagement framework Welsh Government has requested that Llais provide support to Health Board chairs of Maternity and Neonatal Voices Partnerships, and to set up a national forum to share best practice / key learning and escalate any issues to NHS Performance and Improvement to Welsh Government. The first meeting took place Feb 26. Welsh Government have committed to supporting any training requirements.
	iii. A Perinatal Stakeholder Group The assurance assessment panel has been advised by a wider stakeholder group including the voluntary sector, advocacy representatives, UK bodies such as the NMC and the GMC and representatives of different staff groups, including allied health professionals. We recommend that it is retained to meet quarterly and to have Terms of Reference that enable the views of the group to inform the national strategic oversight board. Its current membership should be reviewed, and we suggest it is expanded to include educators, researchers and student representatives.	**Accept**	Welsh Government will work with NHS Performance and Improvement to review and expand the membership of the stakeholder group and establish this as an ongoing group which meets regularly and has published terms of reference. An annual in-person event for all groups to meet to establish processes for change and review progress against previous actions will be held.

	We also recommend that once a year the national perinatal team convenes with the oversight board, the National Women, Parents and Communities Maternity and Neonatal Group and the Perinatal Stakeholder Group for an in-person, collaborative event.	**Accept**	
	b. Data and Monitoring The national oversight group should be responsible for systematic, joined-up monitoring of comprehensive data sets at a national level, with real-time monitoring of critical safety indicators. To enable this, the development and implementation of the national Beacon dashboard should be urgently prioritised and its use to drive whole-system understanding and improvements implemented. This data should be made publicly available in regular reports. The Welsh Government should additionally, and at pace, implement an additional safety signals dashboard, such as the MOSS dashboard recently implemented in England, to enable real-time monitoring of key safety indicators across maternity and neonatal services in Wales, and swift intervention as required. This should be monitored by a subgroup of the national oversight group and include requisite clinical and academic expertise.	**Accept**	The Beacon dashboard is already operational across Wales. The Badgernet digital maternity system will be operational in all health boards in Wales by April 2026. The digital maternity roll out includes maternity data recording and reporting standards which will inform a national dashboard. Wales has been part of the steering group for the development of the MOSS data signalling system led by NHS England which is currently being rolled out across England. Digital Health and Care Wales (DHCW) will undertake an assessment of the infrastructure and costs required to implement this in Wales.

	c. National Governance We recommend that an accessible map and explanation of the complex landscape of governance is published within six months of the publication of this report.	**Accept**	Welsh Government are developing a Clinical Government Framework which will be published in September 2026.
2. A universal offer of quality care throughout the perinatal journey	We recommend that the current rates of continuity of care by midwives is assessed in 2026-7, utilising the newly digitalised individual maternity health record; and a meaningful plan developed to increase continuity of care co-produced between the Welsh Government, Health Education and Improvement Wales, Health Boards, staff and women and families. Women with more complex social and health needs should be prioritised for continuity of care in the first stages of implementation.	**Accept**	The Chief Midwifery Officer in Welsh Government will establish a task and finish group which includes representatives from across NHS Wales, staff, women and families to review the best model of continuity of care. This plan will be published in December 2026.
	We recommend that the Welsh Government requires all maternity, neonatal and relevant education providers to actively progress through the stages of UNICEF UK Baby Friendly Initiative accreditation.	**Accept**	Welsh Government will renew the identified requirement for UNICEF accreditation across all health boards and Higher Education Institutions in the Infant Feeding Plan. This plan will be developed during 2026-27.
	Health Boards should ensure that a birth discussion takes place with a suitable member of the multidisciplinary team involved in their care, before discharge from maternity services. Where applicable	**Accept**	Welsh Government will strengthen guidance to Health Boards, alongside the Quality Statement, setting out expectations to ensure birth discussions

	neonatal services should be involved in these discussions. This should be routinely offered, in addition to the valuable Birth Reflections service which may take place several weeks after a birth, when requested. Welsh Government should support Health Boards to provide clear, accessible and accurate information to the public by providing templates for social media campaigns that can be adapted at a regional level.	 **Accept**	take place as a routine part of maternity and neonatal care. Welsh Government will work with Public Health Wales and Health Board Communications teams to develop a national communications plan for consideration by the National Oversight Board.
3. Urgent attention to critical clinical safety issues	Welsh Government should move forward at pace in 2026 to commission and implement the planned national triage line. It should also publish a standardised service model for in-person triage with consistent terminology, ensuring 24/7 availability supported by dedicated staff and reliable senior clinical presence. In-person triage services should not include scheduled antenatal or postnatal assessments. Induction of labour: A clear national service specification is required to ensure that Health Boards align with current, evidence-based guidance on informed decision making, care planning and timely	**Accept** **Accept**	A scoping exercise for a national maternity triage line is underway and is due to report in March 2026. It will provide recommendations to Welsh Government on the approach to implementation and will include costs and timescales. NHS Performance and Improvement will develop a service specification in 2026-27 for in-person triage overseen by the National Oversight Board. NHS performance and improvement will work with the Health Boards to develop a service specification for induction of labour.

	access to care. The service specification should also publish a standardised service model to deliver induction of labour which describes the admission pathway, place of care, dedicated workforce and discussion of induction of labour capacity and flow in daily perinatal 'huddles' (multidisciplinary discussions).		
4. Adequate staffing and estates to deliver safe and quality care	a. At a national level, there should be the development and implementation of a workforce planning tool for a multidisciplinary workforce model for maternity services to mirror and integrate with the BAPM standards for neonatal services. This should include adequate levels of allied health professionals, psychology and pharmacy, and should replace the current mandatory use of Birthrate Plus®. It should also include all maternity services including antenatal, postnatal and midwifery care and services for women with additional social and cultural needs. Health Boards must address immediate staffing pressures while national workforce specifications for maternity services are redeveloped.	**Accept**	HEIW have undertaken a review of available acuity tools and published a perinatal workforce plan. NHS Performance and Improvement are currently developing a perinatal workforce service specification to sit alongside the plan which will be published April 2026. We recognise that the current workforce tools do not reflect the multi-disciplinary team needed for the increasing complexity of care. Welsh Government are in early discussion with UK Government to develop a multi-disciplinary workforce planning tool for use across the UK. The National Staffing Programme in NHS Performance and Improvement will lead this work with the Chief Midwifery Officer. Welsh Government will seek assurance that health boards have workforce plans in place with appropriate staff establishments through the relevant performance and assurance mechanisms.

	a. A maternal medicine clinical network This should be commissioned by the NHS Wales Joint Commissioning Committee. Alongside this work, NHS P&I should facilitate the review of clinical pathways for rare but serious pregnancy-related conditions such as placenta accreta spectrum, to ensure that there are clear, consistent and commissioned routes for expert assessment and treatment, within Wales or from clinicians based in other UK nations.	**Accept**	NHS Performance and Improvement has written to the Joint Commissioning Committee outlining the requirement for a maternal medicine clinical network focused on rare conditions. The JCC have submitted this as a commissioning intention within the Integrated Medium-Term Plan and currently under consideration.
	b. Adequate theatre estate and capacity Each Health Board should review their theatre estate and capacity, reflecting current and future need. This should incorporate a plan for adequate theatre staffing (medical and non-medical) and that maternity theatres are appropriately located and equipped within the maternity and neonatal service footprint to enable timely support for the multidisciplinary team caring for women and babies during planned and unplanned surgery.	**Accept**	NHS Performance and Improvement will work with health boards to review current theatre capacity, model future need and develop a service specification on requirements for theatre capacity and staffing levels, in the context of increasing rates of caesarean section. This aligns with wider work in Planned Care to review theatre utilisation and allows workforce modelling work to be undertaken to inform this work.
5. Mental health support	The Welsh Government should develop and publish a national service specification for perinatal mental health pathways that encompass both common mental health	**Accept in part**	National pathways for perinatal mental health have been developed and are in place across Health Boards. Health Boards are expected to adhere to RCPsych standards for community perinatal mental

	conditions and moderate to severe conditions experienced by women, as well as services for fathers/partners and parent-infant relationships.		health services and have received funding to bring services in line with the standards. The Mental Health and Wellbeing Strategy for Wales sets out that Quality Statements based on the Health and Care Quality Standards will set out the vision for specific clinical services and pathways, and that these will be underpinned by more detailed service specifications describing the outcomes and benefits. There are a range of programmes and services across government which support parent and infant relationships, these services would not be part of an NHS specification for perinatal mental health services.
	Health Boards should ensure that training is embedded for all staff in perinatal services on recognising, responding to and preventing trauma. This should also be completed by all involved in responding to incident processes, including legal teams. This will support the recognition, response and prevention of compounded trauma amongst women, parents and staff.		Welsh Government will work with HEIW and Health Boards to ensure training is available to all staff working in perinatal and support services across NHS Wales.
	Each Health Board should engage in a meaningful process with staff in perinatal services to seek an in-depth understanding of staff mental health and well-being needs and co-produce improved support and care structures. Health Boards should review and monitor the effectiveness of this		Health Boards are responsible for ensuring relevant support services are in place for staff wellbeing. Welsh Government will write to Directors of Workforce and Organisational Development seeking assurance that they will review current provision and work with staff to improve the offer where necessary.

	through collaborative and transparent methods of engagement.		
6. Optimal neonatal care commissioning	Commissioning: there is an urgent need for the NHS Wales Joint Commissioning Committee, to complete the required analysis and commissioning decisions relating to neonatal cot configuration and neonatal transport. This should also include consideration of how to maximise the quality and capacity of transitional care. The Welsh Government should accelerate implementation of a national maternity bed and neonatal bed/cot locator with 24/7 availability, dedicated staffing, senior clinical oversight and a single point of access.	**Accept**	The Joint Commissioning Committee will complete the required analysis to inform commissioning decisions for a national neonatal transport service and neonatal cot configuration. This work is due to complete by September 2026 in line with wider work being carried out by WAST on the Cot Bed Locator Project. This analysis will inform decisions and planning work to implement the transport and cot locator service.
7. A reliable process for review and investigation, that involves families and leads to timely learning	A clear, accessible, publicly available Standard Operating Procedure for maternity and neonatal services in Wales for incident response and management. This should include a flowchart that demonstrates the processes and timescales that must be followed to align with Welsh legislation and guidance, and UK frameworks. It must be family-centred and trauma-informed, using restorative justice approaches.	**Accept**	NHS Performance and Improvement will develop a Standard Operating Procedure, in 2026-27, for maternity and neonatal services in Wales for incident response and management. This will be considered by the National Strategic Oversight Board.

	A specialist subcommittee of the National Strategic Oversight Board (as described in Priority 1) to oversee Health Boards' operational delivery of the perinatal National Reportable Incident process. This should include multidisciplinary clinical leads, a lay patient advocate, the Welsh Risk Pool and academic expertise to ensure that processes are family-centred, timely and learning is shared. It could also ensure that thematic learning is drawn from perinatal incident reporting and produce national thematic reports. A national perinatal repository, to include Local and National Reportable Incidents which would enable and report on systematic and meaningful learning.		NHS Performance and Improvement currently has a National Reportable Incident policy that includes MBBRACE reportable cases. Digital Health and Care Wales (DHCW) will be required to undertake a scoping exercise for the development of a national repository.
8. Developing an in-depth understanding of need, experience and outcomes through engagement and evaluation.	Health Boards should improve how women's, families' and communities' experiences and views are heard and acted on by optimising the implementation of the Perinatal Engagement Framework. Health Boards should improve how the experiences and views of staff are heard and acted upon by implementing meaningful involvement approaches that are co-produced with staff groups.	**Accept**	The Perinatal Engagement Framework, which provides strategic direction to Health Boards, includes an expectation to engage with communities to ensure all voices are heard. Welsh Government and NHS Performance and Improvement have developed Perinatal Engagement Measures for Wales. This is currently being rolled out through the Civica Patient Feedback System across Maternity and Neonatal services. This will be complete by June 2026. Welsh Government will engage with the wider UK Governments to determine whether they wish to

	The Welsh Government, possibly jointly with the other UK Governments, should commission a programme of research on the costs and short, medium and long-term consequences of the current and emerging model of care Health Boards should test and evaluate initiatives to reduce inequalities of experience and outcome, particularly relating to poverty and ethnicity, and share findings at an all-Wales level The Welsh Government should commission an evaluation of the impact and outcomes of the priorities recommended here.		progress this area of work. In parallel, the Welsh Government will utilise data from the current model of care as a baseline to assess improvements as new models are implemented. This analysis will be undertaken using internal knowledge and analytical expertise. Digital maternity Cymru data will provide opportunities for disaggregated data knowledge to inform issues to be addressed to reduce inequalities in maternity outcomes and experience. Robust data collection and evaluation will be built into all the initiatives in response to this recommendation.