Appendices

The path to safer beginnings in Wales
A national assurance assessment of Maternity and Neonatal care and services

February 2026

Appendix A: Panel, Groups and Contributing organisations

Independent Oversight Panel Membership

Name	Role
Prof Sally Holland	Independent Chair
Heidi Smoult	Panel lead for Organisational Leadership, Culture and Governance workstream
Prof Mary Renfrew	Panel lead for Assessment of Quality and Safety workstream
Ken Sutton	Panel lead for Women, Parents and Families Experience workstream
Sue Holden	Panel lead for Staff Experience workstream
Dr Edile Murdoch	Panel lead for 15 Steps Site Visits workstream and Neonatal Panel Advisor
Dr Jo Mountfield	Obstetric Panel Advisor
Sarah Fox	Midwifery Panel Advisor

Stakeholder Group membership

Name	Organisation
Alex Howells	Health Education and Improvement Wales (HEIW)
Alun Jones	Healthcare Inspectorate Wales (HIW)
Amanda Lawes	Swansea Bay University Health Board
Ann Lloyd	Aneurin Bevan University Health Board
Ben Wesson	Nursing and Midwifery Council (NMC)
Carmel Bagness	Royal College of Nursing (RCN)
Carol Shillabeer	Betsi Cadwaladr University Health Board
Caroline Lee-Davey	Bliss
Cerith Waters	Cardiff and Vale University Health Board Perinatal Psychology
Dr Kate Shakespeare	British Psychological Society
Gethin Matthews-Jones	General Medical Council (GMC)
Heather Searle	Royal College of Nursing (RCN)
Jason Roberts	Cardiff and Vale University Health Board
Julie Richards	Royal College of Midwives (RCM)
Ken Sutton	Panel lead for Women, Parents and Families Experience workstream (Vice Chair)
Laura Cartwright	Maternity and Neonatal Voice Partnership - Cwm Taf Morgannwg University Health Board
Lauren Edwards	Allied Health Professions - Cwm Taf Morgannwg University Health Board
Lisa Llewellyn	Health Education and Improvement Wales (HEIW)
Lucie Lewis	Neonatal Nurses Association (NNA)
Lucy Graham	Miscarriage Association
Malcolm Gajraj	The Royal College of Paediatrics and Child Health (RCPCH) Wales
Matt Lewis	Swansea Bay University Health Board
Munira Oza	The Ectopic Pregnancy Trust

Name	Organisation
Prof Sally Holland	Independent Oversight Panel Chair
Rhys Jones	Healthcare Inspectorate Wales (HIW)
Roxanne Treacy	Llais
Sam Jeffreys	RCPCH Wales Exec Committee, RCPCH Trainee Committee, Wales School of Paediatrics
Sandy Harding	Royal College of Nursing (RCN)
Sarah Douglass	Cardiff and Vale University Health Board
Sarah Williamson	Royal College of Paediatrics and Child Health (RCPCH)
Tracey MacCormack	NMC (The Nursing and Midwifery Council)
Vicki Robinson	Miscarriage Association

Members of the Women, Parent and Family Engagement Consultative Group

Name	Organisation or Group Area
Ken Sutton	Independent Panel member (Chair)
Caroline Lee-Davey	Bliss
Chloe Lanzaby	Birth Trauma Association
Racheal McGrath	Birth Trauma Association
Laura Cartwright	Cwm Taf Morgannwg Maternity and Neonatal Voices Partnership
Mahaboob Basa	Muslim Community Swansea
Roxanne Treacy	Llais
Sarah Fox	Midwifery Panel Advisor

List of organisations that participated in the listening sessions

Contributing individuals or organisations	Area
Baby Shower Cwm Taff	Maesteg
Buckley Breast Feeding Group	Wrexham
Chinese Community	National
Dinky Dragons	Newport
Eyst Mens Muslim Community Group	Cardiff
Eyst Women's Muslim Community Group	Cardiff
Little Chicks Playgroup	Cwmbach, Aberdare
Llwynhendy Childrens Centre	Carmarthenshire
Neonatal Support Group	Princess of Wales
Family Meeting	St Asaph
Parent and Baby Group/Flying Start	Abergele
Sut Mae Dad	Bangor
Mothers Matter	The Hub, Tonypandy
Tirion Birth Centre	Royal Glamorgan Hospital
Welshpool Baby Massage Group	Welshpool
Womens Advocacy Network	Grange Town, Cardiff

Appendix B: Glossary of terms

Acuity	A measure a patient's condition and the intensity or complexity of clinical care they require, often used to determine staffing levels.
Alongside midwifery led unit (AMU)	. An alongside midwifery led unit is located in the same building as an obstetric unit so it has access obstetric, neonatal and anaesthetic care if required.
Antenatal	The period between conception and birth
BadgerNet® Neonatal	The electronic medical record containing neonatal care records, used by hospitals in Wales and across the UK
BadgerNet® Maternity	The electronic medical record containing maternity care records, in place in a small number of health boards across Wales.
Birthrate Plus®	A workforce planning tool used in the UK to calculate midwifery staffing levels.
Body Mass Index (BMI)	Body Mass Index (BMI) a measurement to work out the range of healthy weights for a person. It is calculated by dividing your weight (in kilograms) by your height (in metres squared – that is, your height in metres multiplied by itself). The healthy range is between 19 and 25.
Bronchopulmonary Dysplasia	A chronic lung disease that primarily affects premature babies, causing inflammation and scarring in the lungs leading to underdeveloped airways and air sacs.
Caesarean Birth	An operation in which a baby is born through a cut made in the wall of the abdomen and the uterus. It may be done as a planned (elective) or an emergency procedure.

Cymru Inter-Hospital Acute Neonatal Transfer Service (CHANTS)	A transport service for critically ill or premature babies between neonatal units in South Wales and to/from England.
Childbearing Women	Females within their reproductive years, commonly cited as ages 15-45, who are physiologically capable of conceiving and giving birth. This term is used in medical and demographic contexts to identify individuals with the potential for pregnancy.
Deprivation	Deprivation refers to the lack of necessary resources, socioeconomic stability, and access to opportunities such as income, education, employment, and adequate housing that directly impacts the health of a pregnant person and their baby.
Digital Maternity Cymru	Programme to oversee implementation of Badgernet® across NHS Wales
Doula	A non-medical professional, not employed by or affiliated with the NHS, who provides support to individuals and families before, during, and after childbirth.
Duty of Candour	A legal requirement introduced in April 2023 for all NHS organisations to be open and honest with patients, service users, or their families when they experience unexpected or unintended moderate/severe harm, or death, while receiving care.
Extended Perinatal Death	This refers to all stillbirths and neonatal deaths
Extreme Preterm Infant	Babies born before 27 completed weeks of gestation
Ex-Utero Transfer	The transfer of a baby to a different hospital after the baby is born.
Family Integrated Care (FiCare)	Family Integrated Care is a model of neonatal care that promotes a culture of partnership between parents, carers and health care professionals working together to care for babies on the neonatal unit
Flying Start	Flying Start is the Welsh Government's targeted Early Years programme for families with children under 4 years of age who live in some of the most disadvantaged areas of Wales.
Forceps	Smooth, metal instruments used by obstetricians to assist in the birth of a baby.
Freestanding Midwifery Unit (FMU)	A facility where midwives have primary responsibility for care of women at low risk of complications during labour and birth which is not located on the same site as an obstetric unit.

Gestation	The process/period of a foetus developing inside the uterus between conception and birth.
Global Majority	A collective term for people of Black, Asian, Brown, dual-heritage, or Indigenous descent, and those from the Global South, who constitute approximately 85% of the world's population
Governance	The processes, structures, and accountabilities ensuring organisations deliver high-quality, safe, effective care, manage risks, and use resources efficiently.
Health and Care Quality Standards (HCQS)	Introduced on April 1, 2023, the HCQS mandate that all NHS Wales services deliver high-quality, person-centred care under a statutory 'Duty of Quality'. The standards comprise six core dimensions: Safe, Timely, Effective, Efficient, Equitable, and Person-Centred, which are supported by key enablers: leadership, workforce, culture, information, and improvement.
Health Board	There are seven health boards in Wales. Each health board is responsible for delivering and/or commissioning all NHS healthcare services within a geographical area.
Health Education and Improvement Wales (HEIW)	The NHS Wales organisation responsible for strategic education commissioning, training, and workforce development.
Health Inspectorate Wales (HIW)	The independent inspectorate and regulator of healthcare services in Wales.
Health Visitor	A qualified nurse or midwife with specialised training in community public health, focusing on the development and wellbeing of children aged 0–5.
Hypoxic-ischaemic Encephalopathy	A brain injury in newborns caused by a lack of oxygen and blood flow (hypoxia-ischemia) around the time of birth, leading to brain dysfunction.
Integrated Quality, Planning & Delivery (IQPD) Meetings	Welsh Government-led meetings designed to monitor health board service delivery.
Initial Assessment	The maternity pathway initial assessment, sometimes referred to as the booking appointment, is the first comprehensive, contact with a midwife to assess the health and social needs of a pregnant person and their baby.
Intrapartum Care	The term used to describe care given to women during labour and birth

Intraventricular Haemorrhage	Bleeding into the fluid-filled spaces (ventricles) within the brain, most commonly occurring as a complication of premature birth due to fragile blood vessels.
In-utero Transfer	The transfer of a pregnant woman to a different hospital before birth.
NHS Wales Joint Commissioning Committee (JCC)	A collaborative body formed by Wales's seven health boards to plan, secure, and commission specific specialised NHS Wales services.
Joint Strategic Needs Assessment (JSNA)	A process used by local authorities, the NHS, and partners to analyse the current and future health, social care, and wellbeing needs of a local community.
Labour	The stages of childbirth. Labour is divided into three stages; first, second and third.
Late fetal loss (MBRRACE-UK definition)	A baby born at 22 and 23 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.
Late preterm infant	Babies born between 34-36+6 completed weeks of gestation
Local Neonatal Unit (LNU)	A neonatal unit that provides high dependency or short-term intensive care for babies born from 27 weeks completed gestation.
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE -UK)	The collaboration that undertakes the national Maternal, Newborn and Infant Clinical Outcome Review Programme, conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths
National Learning Advisory Panel (LAP)	A clinically led, multi-professional group that acts as a subcommittee of the Welsh Risk Pool Committee (WRPC).
National Strategic Clinical Network for Maternity and Neonatal Services	Whilst the National Strategic Clinical Network for Maternity and Neonatal Services was formally established on the 1 April 2024, there has been a well-established maternity and neonatal network in Wales since 2019. The network was part of the NHS Executive which then became NHS Performance and Improvement in 2025.
Necrotising Enterocolitis (NEC)	A severe illness, primarily affecting premature babies, where intestinal (gut) tissue becomes inflamed, damaged, and can die.

NICU (Neonatal Intensive Care Unit)	A neonatal unit that cares for babies born who are born extremely premature or sick, who require intensive care as well as those who may need high dependency or special care.
Midwifery Led Care	Care for pregnant women where the midwife is the lead professional. Midwifery-led care is suitable for healthy women who have a low risk, uncomplicated pregnancy
Miscarriage	Spontaneous ending of a pregnancy before 24 weeks' gestation
Mode of Birth	How a baby is birthed, categorised as vaginal (spontaneous or assisted) or via caesarean section.
Maternity and Neonatal Safety Support Programme (MatNeoSSP)	2023 Discovery Report, and subsequent implementation programme, to support the quality and safety of maternity and neonatal services in Wales.
Maternal Mortality	Maternal mortality is the death of a woman during pregnancy, childbirth, or within 42 days of the end of the pregnancy, caused by complications related to the pregnancy or its management.
National Neonatal Audit Programme (NNAP)	NNAP assesses whether babies admitted to neonatal units in Wales, England and Scotland receive consistent high-quality care and identify areas for quality improvement.
National Reportable Incidents (NRI)	Patient safety incidents causing significant harm (moderate, severe, or death) that must be reported.
Neonatal	The neonatal period is the time from a live birth up to 28 days following birth. This includes babies born preterm and term.
Neonatal Death (MBRRACE-UK definition)	A live born baby (born from 20 completed weeks' gestation) who died before 28 days after birth.
Neonatal Unit	A hospital ward for the provision of specialist care to neonates. Neonatal care is organised according to both a description of the type of unit providing the care and the level of care provided.
Neonate	A newborn infant
Neonatal Intensive Care Unit (NICU)	A neonatal unit that cares for babies who are born extremely premature or sick, who require intensive care as well as those who may need high dependency or special care.
Out of Guidance	Choosing maternity care that differs from standard guidelines.
Outlier	Performing statistically above or below expected

Patient Reported Experience Measures (PREMs)	Validated surveys that capture a patient's personal perspective on the care they received.
Parity	The number of times a woman has given birth, including live births at any gestation and all births from 24 weeks or more.
Perinatal	A number of definitions are used for the 'perinatal period'. The term perinatal for the purpose of the assurance exercise encompasses the pathway of maternity and neonatal care
Perinatal Mortality Review Tool (PMRT)	A web-based, standardised tool for NHS maternity and neonatal units in the UK, which enables multidisciplinary reviews of care after a baby's death (late miscarriage to 28 days post-birth).
Perineal Trauma	Damage to the perineum, the area between the vagina and anus, during childbirth.
Postnatal/postpartum	The period from birth until 6 weeks following birth.
Postnatal care	Care provided to woman and baby, from birth for approx. 6 weeks.
Postpartum Haemorrhage (PPH)	Severe bleeding after childbirth. ,
Preceptorship	A structured support program for newly qualified healthcare professionals to develop confidence and competence.
Preterm Birth	A birth before 37 completed weeks of pregnancy, rather than the full 40 weeks.
PROMPT Training	PROMPT (Practical obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies.
Protected Characteristics	The Equality Act 2010 defines nine protected characteristics which serve to protect individuals from discrimination, harassment, or victimisation in the workplace, provision of services and wider society: age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion/belief, sex, and sexual orientation.
Psychological Safety	'A belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes, and that the team is safe for interpersonal risk taking' - Amy Edmundson

Retinopathy of Prematurity	An eye disease affecting premature babies, where abnormal blood vessels grow in the retina (the light-sensitive tissue at the back of the eye), disrupting its normal development.
Schwartz Rounds	Structured forums designed for healthcare staff (clinical and non-clinical) to discuss the emotional and social challenges of working in healthcare.
Speaking Up Safely Framework	An NHS Wales framework designed to foster a culture where staff feel safe to raise concerns without fear of reprisal.
Special Care Baby Unit (SCBU or SCU)	A neonatal unit that cares for babies born after 32 weeks of gestation and who don't need intensive care. **NB. This is increased to 34 weeks' gestation in twins/ multiples for SCU's in South Wales**
Sub-regional Neonatal Intensive Care Centre (SuRNiCC)	A neonatal unit specific to Wales that cares for babies born from 26 weeks completed gestation who are 1kg or heavier
Stillbirth (MBRRACE-UK definition)	A baby born from 24 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.
Streamlining	A scheme designed to efficiently match final-year student midwives and nurses with employment opportunities across Welsh Health Boards.
Term	Babies born on or after the 37th completed week of pregnancy.
Transitional Care (TC)	Transitional care supports resident mothers/parents as primary care providers for their babies with care requirements more than normal newborn care but not needing admission to the neonatal unit.
Trauma Informed Approach	Where a person, organisation, programme or system realises the impact of trauma and understands potential paths for healing and overcoming adversity and trauma.
Triage	A standardised system to determine clinical urgency and onward care pathway, ensuring women are prioritised in order of clinical urgency.
UNICEF	UNICEF is the United Nations Children's Fund. It is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.

UNISON	The UK's largest health union
Venous Thromboembolism (VTE)	A serious condition involving a blood clot in a vein.
Ventouse	A vacuum cup which is attached to the baby's head by suction.
Welsh Risk Pool (WRP)	A unit within the NHS Wales Shared Service Partnership (NWSSP) Legal and Risk Service that manages indemnity, claims, and risk assessment for all NHS Trusts and Health Boards in Wales.

Appendix C: Organisational self-assessment maturity rubric

Domain	Assessment Statement		Example Evidence	Maturity Level			
				1	2	3	4
Organisational Culture & Values	1.1a	Staff feel psychologically safe and confident to raise concerns without fear of blame.	Staff survey results; Staff survey free text; Freedom to Speak Up Guardian reports; HR data on whistleblowing; Systems-approach to incident learning	No evidence of psychological safety; staff fear repercussions for raising concerns.	Staff reporting psychological safety is variable.	Majority of staff report ability to raise concerns without fear, though some variability across teams.	Psychological safety is fully embedded across the service; staff consistently raise concerns without fear.
Organisational Culture & Values	1.1b	The Speaking up Safely framework is embedded with a clear escalation system operating from ward to board	Freedom to Speak Up Guardian reports; HR data on whistleblowing; Board minutes showing escalated issues and actions.	No evidence of review of Speak up reports	Formal speaking up processes in place but are inconsistently used	Escalation systems routinely used from ward to board with consistent follow-through.	Speaking-up practices are shared in ways that influence wider teams.

Domain	Assessment Statement	Example Evidence	Maturity Level			
			1	2	3	4
Organisational Culture & Values	1.2	The service consistently demonstrates respectful, compassionate, person-centred care, evidenced by women, parent and family feedback; including support for autonomy and informed consent.	Women, parent and family surveys; PREMs data; consent audit results; case reviews; training records.	Evidence of women, parent and family complaints relating to lack of respect/consent.	Some positive women, parent and family feedback; autonomy and informed consent not consistently supported.	Women, parent and family feedback largely positive; autonomy and informed consent documented but not systematically monitored.	Respectful, compassionate, person-centred care is consistent; autonomy and consent audited and supported through training and monitoring.
Organisational Culture & Values	1.3	The Board and service leadership teams value and include diverse perspectives in developing continuous improvement plans.	QI project reports; staff focus groups; Women, parent and family panels; Equality Impact Assessments; Board papers showing changes from feedback.	Improvement decisions made without input from diverse perspectives.	Some ad-hoc collection of views; diversity of perspectives not consistently acted upon.	Diverse perspectives (staff/ women, parent and families) collected and inform some improvement projects.	Diverse perspectives systematically inform improvement priorities; feedback from staff and women, parent and families is actively used to shape Perinatal service improvements.
Organisational Culture & Values	1.4	Leadership communicates organisational values consistently communicated through two-way channels, with evidence of observable impact on staff behaviour and visible Board involvement.	Internal comms strategy; staff survey results; observation/ behaviour audits; Board walkround reports.	Organisational values exist but not actively communicated or demonstrated.	Values regularly communicated and visible in some areas; partial evidence of impact on staff behaviour	Two-way communication channels consistently reinforce values; Board visibility evident; staff behaviours aligned to values.	Organisational values are visible, consistently reinforced, and influence behaviours at all levels; leadership engagement drives culture alignment across the Perinatal service.
Clinical & Professional Leadership	2.1a	Clinical leaders are identifiable at all levels, with named consultant, midwifery and neo-natal nursing leads accountable for safety and quality.	Organisational charts; rota of consultant leads; Board reports on safety escalations.	Clinical leadership unclear; staff unsure who holds accountability for safety and quality.	Consultant, midwifery and neo-natal nursing leads named for safety/quality but variable engagement	Consultant, midwifery and neo-natal nursing leads demonstrably accountable for ward-to-board safety and quality.	Accountability for safety and quality is demonstrably embedded and influences Perinatal team performance and outcomes
Clinical & Professional Leadership	2.1b	Clinical leaders are visible in frontline areas	Staff survey feedback; Board reports on safety escalations	Staff report lack of visibility and accessibility to clinical leaders.	Clinical leaders are visible in some areas	Clinical leaders are consistently visible and accessible at frontline	Clinical leaders are consistently visible and accessible across all shifts

Domain	Assessment Statement	Example Evidence	Maturity Level			
			1	2	3	4
Clinical & Professional Leadership	2.2 Leadership actively promotes safe, high-quality care and staff wellbeing, with defined escalation routes from ward to board.	Escalation flowcharts; wellbeing programme participation data; staff survey results; incident review evidence.	No formal escalation processes; leadership focus on safety/ wellbeing minimal.	Escalation routes exist but poorly understood; wellbeing initiatives ad hoc.	Escalation processes documented and generally followed; leadership visible in safety/ wellbeing promotion.	Escalation routes embedded and routinely used; leaders actively promote safety/wellbeing and support staff.
Clinical & Professional Leadership	2.3a Multidisciplinary leadership teams collaborate regularly, including consultant-led ward rounds, with clear processes, documented decision-making and shared accountability.	MDT meeting minutes; consultant rota; ward round documentation; QI project reports; ward rounds in different settings	MDT leadership rare; ward rounds inconsistent; decisions poorly documented.	MDT leadership occurs but irregular; consultant involvement inconsistent.	Regular consultant-led MDT ward rounds with consistent documentation; clear shared accountability across professional groups.	MDT leadership is embedded; consultant-led ward rounds and shared Perinatal decision-making are routine, with clear accountability improving outcomes across professional groups.
Clinical & Professional Leadership	2.3b Multidisciplinary Perinatal leadership team meetings take place with appropriate professional representation to plan care for women with complex needs	Records of meetings where women's requests for care outside of usual clinical guidance is discussed; records of discussions and documentations of agreement and mitigations in these areas	MDT leadership meetings are rare; with no discussions on whole maternity journey for women	MDT leadership meetings occur, but limited professional involvement; whole maternity journey discussions are limited	MDT leadership meetings are held regularly and regularly; with topics chosen multi-p review whole maternity journeys with documentation of decisions and mitigations where required	MDT leadership meetings are embedded and review whole maternity journeys with decisions and mitigations recorded with subsequent shared accountability
Clinical & Professional Leadership	2.4 There is a formal leadership development and succession planning, inclusive of diverse future leaders supported by resources for leadership development.	Talent pipeline plans; leadership programme uptake data; diversity monitoring; Board succession planning documents.	No succession planning or development support; leadership lacks diversity.	Some leadership development offered; succession planning informal and limited.	Structured leadership programmes in place; succession planning emerging with partial diversity focus.	Formal, resourced succession planning inclusive of diverse staff; leadership development supported at multiple levels.

Domain	Assessment Statement		Example Evidence	Maturity Level			
				1	2	3	4
Governance & Accountability Structures	3.1	Governance structures for perinatal care are clearly documented, understood by staff, and regularly reviewed; including integrated safeguarding systems with partner agencies.	Governance framework documents; safeguarding policies; staff survey on governance clarity; joint audits with partner agencies.	Governance structures unclear or undocumented; safeguarding not integrated.	Basic governance framework exists but poorly understood; safeguarding siloed.	Governance framework clear, understood across staff groups; integrated safeguarding systems embedded and tested with partner agencies	Governance frameworks and safeguarding systems are fully embedded across services, routinely reviewed, and consistently applied; learning is used to improve practice across Perinatal teams
Governance & Accountability Structures	3.2	Risks are proactively identified, assessed at every contact, communicated and escalated through local and national governance systems, with timely learning fed back to teams.	Risk registers; incident logs; escalation records; staff feedback on learning; national reporting submissions.	Risk management ad hoc; escalation inconsistent; learning rarely shared.	Risk identification processes exist but not applied consistently; feedback loops weak.	Risks routinely identified and escalated; learning shared but variable timeliness.	Risks systematically assessed at every contact; timely escalation embedded; learning consistently fed back to teams
Governance & Accountability Structures	3.3	Demand/Capacity, staffing ratios, quality and safety performance is tracked against agreed indicators and through integrated perinatal datasets/digital systems, benchmarked, and publicly reported via dashboards.	Workforce dashboards; perinatal dataset extracts; public board reports; benchmarking reports; NHS digital submissions.	No systematic monitoring of demand, staffing or performance.	Some monitoring of demand/capacity and staffing ratios; datasets incomplete or manual.	Regular tracking of demand/capacity, staffing and performance against indicators; some benchmarking.	Integrated perinatal datasets and digital systems used for real-time monitoring; dashboards publicly reported; benchmarking routine.
Governance & Accountability Structures	3.4	Audit and review findings drive actions with monitored completion, duty of candour and meaningful parent/family involvement.	Audit schedules; duty of candour reports; action trackers; family involvement records; external review findings.	Audits and reviews infrequent; little follow-through; limited family involvement.	Some audits/reviews completed; actions recorded but not always monitored; family involvement rare.	Audit and review findings consistently drive monitored actions; duty of candour upheld; meaningful family involvement embedded.	Audit and review findings consistently drive actions; duty of candour and meaningful parent/family involvement are embedded across Perinatal pathways and inform ongoing improvement.

Domain	Assessment Statement	Example Evidence	Maturity Level			
			1	2	3	4
Quality of Care & Women, Parent and Family Outcomes	4.1 Outcomes are measured across clinical, experience, and equity dimensions and population health insights, including learning from perinatal mortality reviews, to inform targeted improvements.	Mortality review reports; PREMs/PROMs data; equity audit reports; population health dashboards; improvement plans linked to outcomes.	Outcomes not routinely collected; no systematic use of mortality reviews.	Some outcomes collected (mainly clinical); perinatal mortality reviews occur but learning inconsistently applied.	Outcomes collected across clinical and experience dimensions; some equity and population health insights included.	Outcomes routinely measured across all dimensions (clinical, experience, equity, population health); learning from perinatal mortality reviews embedded in improvement.
Quality of Care & Women, Parent and Family Outcomes	4.2 Care pathways follow best evidence, are personalised and support continuity of carer, bereavement care pathways, family integrated care and transitional care to avoid separation.	Clinical guidelines; care pathway documentation; FiCare programme reports; bereavement care audits; women, parent and family feedback.	Care pathways variable; no consistent evidence base or personalisation.	Some evidence-based pathways in place; personalisation and continuity limited.	Pathways consistently evidence-based, personalised and inclusive of continuity of carer, bereavement, FiCare and transitional care.	Perinatal care pathways are consistently evidence-based, personalised, and embedded; continuity of carer, bereavement, family-integrated, and transitional care are optimised.
Quality of Care & Women, Parent and Family Outcomes	4.3 Learning from incidents, near misses, and complaints is timely and transparent in line with duty of candour, with women, parent and family involvement and external clinical input where appropriate.	Incident/complaint logs; duty of candour reports; review minutes including women, parent and family involvement; external review findings.	Incidents and complaints inconsistently reported; little evidence of learning or women, parent and family involvement.	Some reporting and review occurs; feedback not timely; women, parent and family involvement minimal.	Learning from incidents, near misses and complaints consistently timely and transparent; women, parent and families routinely engaged in reviews; external input sought when appropriate.	Learning from incidents, near misses, and complaints is timely and transparent; women, parent and families routinely contribute, and improvements are consistently applied across Perinatal teams.
Quality of Care & Women, Parent and Family Outcomes	4.4 Staff are competent and confident to carry out their relevant roles and to work effectively across an MDT.	Training; competency and supervision records at individual and at MDT level	Staff demonstrate basic competence in core tasks; minimal understanding of other MDT roles; collaboration is siloed and reactive.	Staff demonstrate competence in core aspects of their role with growing confidence; recognise need to work in collaboration with MDT.	Staff are consistently competent and confident; clear understanding of their own role and those of MDT colleagues; proactive, regular collaboration	Staff are highly competent, confident, and act as role models; MDT working is seamless, with strong integration and mutual respect.

Domain	Assessment Statement		Example Evidence	Maturity Level			
				1	2	3	4
Quality of Care & Women, Parent and Family Outcomes	4.5	Improvement projects show measurable, sustained results aligned with national programmes, demonstrate women, parent and family impact and efficient/ sustainable use of resources.	QI project reports; evaluation findings; national programme alignment documents; cost-benefit analyses; women, parent and families feedback on improvements.	Improvement projects rare or unmonitored; minimal women, parent and family impact.	Staff demonstrate competence in core aspects of their role with growing confidence; recognise need to work in collaboration with MDT.	Staff are consistently competent and confident; clear understanding of their own role and those of MDT colleagues; proactive, regular collaboration	Staff are highly competent, confident, and act as role models; MDT working is seamless, with strong integration and mutual respect.
Staff Experience, Voice, & Engagement	5.1	Staff feedback is actively sought with actions and impacts communicated back.	Staff survey results; Staff survey free text; pulse survey data; action plans from feedback; communications showing impact of staff voice.	No systematic staff feedback; issues rarely acted on.	Feedback collected occasionally but responses not transparent; little evidence of action.	Feedback consistently collected through multiple mechanisms; including free text; clear actions taken and impacts communicated back to staff.	Staff feedback is systematically collected and acted upon; improvements are clearly communicated and shared, influencing practices across the Perinatal service.
Staff Experience, Voice, & Engagement	5.2	Staff wellbeing is monitored and supported with psychological safety embedded and timely access to support through accessible services and proactive initiatives.	Wellbeing survey results; uptake of support services; occupational health reports; staff focus groups; external recognition/ awards.	No systematic monitoring of staff wellbeing; support services absent or ad hoc.	Wellbeing support available but limited awareness or access; monitoring minimal.	Wellbeing actively monitored with accessible, timely support; psychological safety embedded across teams.	Staff wellbeing is routinely monitored; accessible support and psychological safety are embedded, with sustained improvements across Perinatal teams.
Staff Experience, Voice, & Engagement	5.3	Staff at all levels have protected time and opportunities for learning and service improvement, with access to service-specific CPD and multiprofessional training.	CPD uptake data; training registers; rota allocations showing protected time; evaluation of training programmes.	No dedicated time or opportunities for CPD; training mostly ad hoc.	Some training available but protected time inconsistent; limited multiprofessional learning.	Protected time consistently embedded; staff routinely access CPD and multiprofessional training; improvement time resourced.	Protected time for learning and service improvement is embedded; staff fully compliant with CPD and multiprofessional training, contributing to continuous Perinatal service improvement.
Staff Experience, Voice, & Engagement	5.4	Decision-making and improvement project activities demonstrably involves diverse staff groups, supporting an inclusive culture.	Project reports showing staff involvement; meeting minutes; equality monitoring data; staff testimonials.	Decision-making limited to senior staff; little diversity of input.	Some involvement of wider staff groups; inclusivity inconsistent.	Inclusive culture evident; diverse staff consistently involved in decision-making and QI projects.	Decision-making and improvement activities consistently involve diverse staff groups; inclusive practices influence service priorities and are embedded across the Perinatal service.

Domain	Assessment Statement		Example Evidence	Maturity Level			
				1	2	3	4
Staff Experience, Voice, & Engagement	5.5	The working environment enables all staff groups to thrive and innovate to drive improvements in a culture of curiosity	Staff survey results; QI project portfolios; notes of staff engagement meetings and leadership forums	Environment is reactive. Curiosity and improvement ideas rarely sought or acted upon	Occasional innovation projects led by a few motivated individuals. Limited structures in place to encourage cross-disciplinary collaboration or staff voice.	Staff wellbeing is actively supported, and multidisciplinary teams collaborate on improvement. Curiosity and innovation are encouraged but not fully embedded in daily culture	Systems exist for staff at all levels to propose and test improvements. Cross-disciplinary innovation is common, and wellbeing support is proactive. Leadership models curiosity and continuous improvement.
Women, Parent, Family & Community Involvement	6.1	Proactive collaboration and engagement with a wide range of stakeholders, including vulnerable groups (women and their families, charities, wider partners) to consider external perspectives when making changes or driving improvements in maternity services through implementation of the all-Wales perinatal engagement framework.	Engagement framework reports; co-production event outputs; service redesign case studies; user panel minutes.	Women, parents and families rarely involved in service planning or evaluation.	Some engagement occurs, but involvement is limited; partial use of the all-Wales engagement framework.	Co-production embedded across design, delivery and evaluation including with vulnerable groups; consistent use of the all-Wales perinatal engagement framework.	Women, parents and families are fully involved in Perinatal service design, delivery, and evaluation; their input consistently shapes practice and informs improvements.
Women, Parent, Family & Community Involvement	6.2	Representative feedback is used to inform priorities, with consistent PREMs, real-time engagement and triangulation with outcomes.	PREMs data; real-time survey results; outcome dashboards; Board reports demonstrating triangulation.	Feedback gathered ad hoc; not representative; no systematic use in planning.	Some structured feedback collected; limited representativeness; outcomes rarely linked.	Representative feedback systematically collected; PREMs and real-time engagement embedded; triangulated with outcome data to shape priorities.	Representative women, parent and families feedback is systematically collected, triangulated with outcomes, and used to shape Perinatal priorities and drive sustained improvements.
Women, Parent, Family & Community Involvement	6.3	Service changes are communicated in accessible formats, in the language and method of choice, with Welsh actively offered.	Bilingual communications; Easy Read materials; comms strategy documents; women, parent and family feedback on accessibility.	Service changes not routinely communicated or only in limited formats/ languages.	Some service information accessible; Welsh and alternative formats provided on request only.	Service changes consistently communicated in accessible formats; Welsh proactively offered alongside other language/ format choices.	Perinatal service information is consistently accessible in multiple formats and languages, including Welsh; communication practices are routinely evaluated and optimised.

Domain	Assessment Statement		Example Evidence	Maturity Level			
				1	2	3	4
Women, Parent, Family & Community Involvement	6.4	Active partnerships with community and advocacy organisations are influencing seamless service delivery across primary, secondary and tertiary care, including regional services.	Partnership agreements; minutes of joint working groups; evidence of pathway redesign; advocacy organisation feedback.	Minimal links with community/advocacy groups; service delivery siloed.	Some community partnerships exist but impact on care pathways limited.	Active partnerships with community/advocacy groups in parts of service; some evidence of influence on pathways.	Strong partnerships embedded; community and advocacy organisations consistently influence seamless service delivery across tiers and regional services.
Women, Parent, Family & Community Involvement	6.5	When things have gone wrong, how are women and their close support network are kept informed of the progress of investigations, and their experiences and impact drive and influence the investigatory lines of enquiry.	Protocol for communication with families; evidence of family input shaping investigation questions or areas of focus; lessons learnt being fed back to families	Communication is inconsistent, reactive, or unclear. Families may only be notified that an investigation is occurring, with little opportunity to share experiences or shape the process.	Some structured updates are provided, often at fixed stages. Family accounts are collected but may not significantly influence investigatory lines of enquiry.	Clear, timely, and compassionate communication is in place. Families' experiences are actively sought and integrated into investigations, influencing findings and recommendations.	Women and their support networks co-design their involvement, receive regular tailored updates, and see how their experiences drive lines of enquiry. The approach is transparent, restorative, and results in system-wide learning and visible change.
Equity, Diversity, & Inclusion	7.1	Targeted, resourced actions to address health inequalities for under-represented groups are delivered and evaluated for impact.	Health equity audits; project evaluations; funding allocations; outcome data by group; external reports.	No targeted actions; inequalities unrecognised or unaddressed.	Some actions identified but unfunded or inconsistently delivered.	Targeted actions delivered for some groups; evaluation limited.	Targeted, resourced actions consistently delivered across under-represented groups; impact evaluated and acted upon.
Equity, Diversity, & Inclusion	7.2	Staff receive cultural competence and inclusion training, with uptake and impact monitored across professional groups.	Training registers; evaluation reports; staff survey results; equality impact assessments; appraisal data.	No training on cultural competence/inclusion.	Some staff receive training but uptake patchy; no evaluation of impact.	All staff groups trained in cultural competence/inclusion; uptake and impact monitored systematically.	All staff receive cultural competence and inclusion training; uptake and impact are routinely monitored, and results in measurable improvements in equity and inclusion.

Domain	Assessment Statement		Example Evidence	Maturity Level			
				1	2	3	4
Equity, Diversity, & Inclusion	7.4	Documented equity, diversity and inclusion initiatives demonstrate measurable improvements in access and outcomes.	EDI action plans; access/outcome metrics; case studies; external recognition; annual equality reports.	EDI initiatives absent or undocumented.	Initiatives implemented with some measurable improvements in access or outcomes.	EDI initiatives consistently documented; measurable improvements in access and outcomes demonstrated.	EDI initiatives are consistently implemented; measurable improvements in access and outcomes are embedded and used to inform ongoing Perinatal strategy.
Learning, Improvement, & Innovation Capacity	8.1	Quality improvement is embedded in daily practice, supported by a clear organisational improvement framework, consistent evaluation and routine sharing of learning.	QI strategy documents; project registers; evaluation reports; learning event records; external recognition.	No clear improvement framework; QI activity ad hoc and uncoordinated.	Some QI projects exist but disconnected from organisational framework.	QI embedded in daily practice; organisational framework consistently applied; learning routinely shared across services.	Quality improvement is fully embedded in daily practice; learning is routinely shared and applied to achieve sustained improvements across the Perinatal service.
Learning, Improvement, & Innovation Capacity	8.2	Staff are trained, encouraged, and supported to innovate and improve services, with recognition for successful initiatives.	Training registers; innovation awards; case studies; evaluation reports; staff survey feedback.	No structured support or training for staff innovation; improvement discouraged.	Some staff access training; improvement initiatives exist but recognition inconsistent.	Wider staff trained and encouraged to participate in improvement; some recognition schemes in place.	Organisation provides structured training and support; successful initiatives recognised and celebrated.
Learning, Improvement, & Innovation Capacity	8.3	Learning from internal and external reviews is transparent, shared and acted upon within defined timescales.	External review reports; action trackers; staff communications; women, parent and families updates; national reporting submissions.	Reviews rarely undertaken or acted upon; little transparency.	Some reviews undertaken; actions recorded but not consistently completed or shared.	Reviews consistently completed; learning transparent and shared; actions delivered within defined timescales.	Learning from internal and external reviews is consistently applied; actions are completed within defined timescales, with evidence of improving practice across the Perinatal service.
Learning, Improvement, & Innovation Capacity	8.4	Successful improvements are sustained, scaled, and evaluated for long-term impact.	Longitudinal evaluation reports; scale-up case studies; research participation data; national dissemination outputs.	Improvements rarely sustained or scaled; no evaluation of long-term impact.	Some improvements sustained; limited evaluation of impact; research participation absent.	Successful improvements routinely sustained, scaled and evaluated; organisation participates in relevant research.	Successful improvements are routinely sustained, scaled, and evaluated; learning informs Perinatal service optimisation and contributes to long-term outcomes.

Appendix D: Organisational self-assessment charts

Average self-assessed scores have been shown in steps of 0.5 to make it easier to see differences between lower and higher scores within each level. For each health board, the charts (Figures 1 to Figure 8) show a single average (mean) score. Where a health board submitted more than one tool (for example, one per unit or service), these scores were combined to give an overall average.

Figure 1: Number of Health Boards by interval of their average score for each statement in Organisational Culture and Values

Perinatal : Number of health boards by interval of their average score for each statement in Organisational Culture & Values

Figure 2: Number of Health Boards by interval of their average score for each statement in Clinical and Professional Leadership

Perinatal : Number of health boards by interval of their average score for each statement in Clinical & Professional Leadership

Statement	Values
2.1a : Clinical leaders are identifiable at all levels, with named consultant, midwifery…	4, 3
2.1b : Clinical leaders are visible in frontline areas.	2, 2, 3
2.2 : Leadership actively promotes safe, high-quality care and staff wellbeing, with defined…	3, 1, 3
2.3a : Multidisciplinary leadership teams collaborate regularly, including consultant-…	3, 2, 1
2.3b : Multidisciplinary Perinatal leadership team meetings take place with appropriate…	1, 1, 2, 3
2.4 : There is a formal leadership development and succession planning, inclusive of…	3, 3, 1

Legend: ■ 1 - 1.4 ■ 1.5 - 1.9 ■ 2 - 2.4 ■ 2.5 - 2.9 ■ 3 - 3.4 ■ 3.5 - 3.9 ■ 4

Figure 3: Number of Health Boards by interval of their average score for each statement in Governance and Accountability Structures

Perinatal : Number of health boards by interval of their average score for each statement in Governance & Accountability Structures

Statement	Values
3.1 : Governance structures for perinatal care are clearly documented, understood by…	5, 1, 1
3.2 : Risks are proactively identified, assessed at every contact, communicated and…	4, 1, 2
3.3 : Demand / Capacity, staffing ratios, quality and safety performance is tracked against…	1, 5, 1
3.4 : Audit and review findings drive actions with monitored completion, duty of candour…	1, 5, 1

Legend: ■ 1 - 1.4 ■ 1.5 - 1.9 ■ 2 - 2.4 ■ 2.5 - 2.9 ■ 3 - 3.4 ■ 3.5 - 3.9 ■ 4

Figure 4: Number of Health Boards by interval of their average score for each statement in Quality of Care and Service User Outcomes

Perinatal : Number of health boards by interval of their average score for each statement in Quality of Care & Service User Outcomes

Statement	Values
4.1 : Outcomes are measured across clinical, experience, and equity dimensions and...	6, 1
4.2 : Care pathways follow best evidence, are personalised and support continuity of...	6, 1
4.3 : Learning from incidents, near misses, and complaints is timely and transparent in line...	7
4.4 : Staff are competent and confident to carry out their relevant roles and to work...	1, 5, 1
4.5 : Improvement projects show measurable, sustained results aligned with national...	1, 1, 4, 1

Legend: ■ 1 - 1.4 ■ 1.5 - 1.9 ■ 2 - 2.4 ■ 2.5 - 2.9 ■ 3 - 3.4 ■ 3.5 - 3.9 ■ 4

Figure 5: Number of Health Boards by interval of their average score for each statement in Staff Experience, Voice and Engagement

Perinatal : Number of health boards by interval of their average score for each statement in Staff Experience, Voice & Engagement

Statement	Values
5.1 : Staff feedback is actively sought with actions and impacts communicated back.	1, 2, 4
5.2 : Staff wellbeing is monitored and supported with psychological safety...	1, 4, 1, 1
5.3 : Staff at all levels have protected time and opportunities for learning and service...	2, 4, 1
5.4 : Decision-making and improvement project activities demonstrably involves...	2, 3, 1, 1
5.5 : The working environment enables all staff groups to thrive and innovate to drive...	2, 4, 1

Legend: ■ 1 - 1.4 ■ 1.5 - 1.9 ■ 2 - 2.4 ■ 2.5 - 2.9 ■ 3 - 3.4 ■ 3.5 - 3.9 ■ 4

Figure 6: Number of Health Boards by interval of their average score for each statement in Service User, Carer and Community Involvement

Perinatal : Number of health boards by interval of their average score for each statement in Service User, Carer & Community Involvement

Figure 7: Number of Health Boards by interval of their average score for each statement in Equity, Diversity and Inclusion

Perinatal : Number of health boards by interval of their average score for each statement in Equity, Diversity & Inclusion
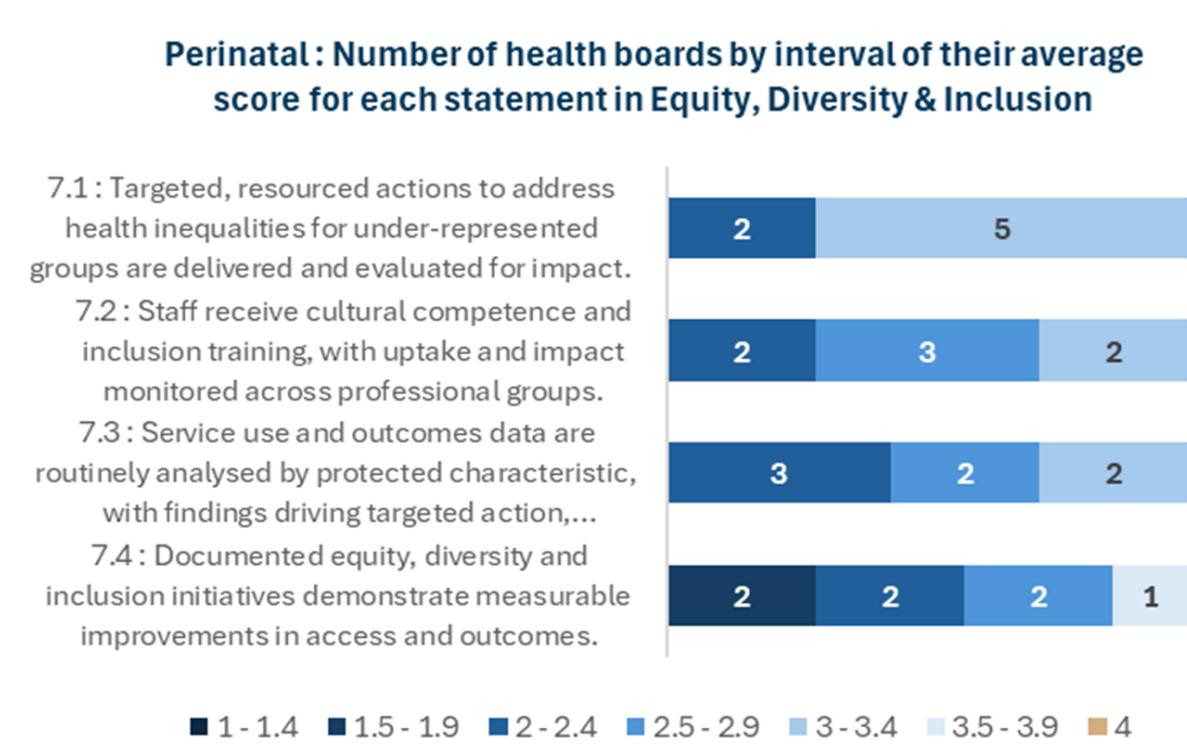
Figure 8: Number of Health Boards by interval of their average score for each statement in Learning, Improvement and Innovation Capacity

Perinatal : Number of health boards by interval of their average score for each statement in Learning, Improvement & Innovation Capacity

Statement		
8.1 : Quality improvement is embedded in daily practice, supported by a clear...	2	5
8.2 : Staff are trained, encouraged, and supported to innovate and improve services,...	1	3	2	1
8.3 : Learning from internal and external reviews is transparent, shared and acted...	1	3	3
8.4 : Successful improvements are sustained, scaled, and evaluated for long-term impact.	1	4	1	1

Legend: ■ 1 - 1.4 ■ 1.5 - 1.9 ■ 2 - 2.4 ■ 2.5 - 2.9 ■ 3 - 3.4 ■ 3.5 - 3.9 ■ 4
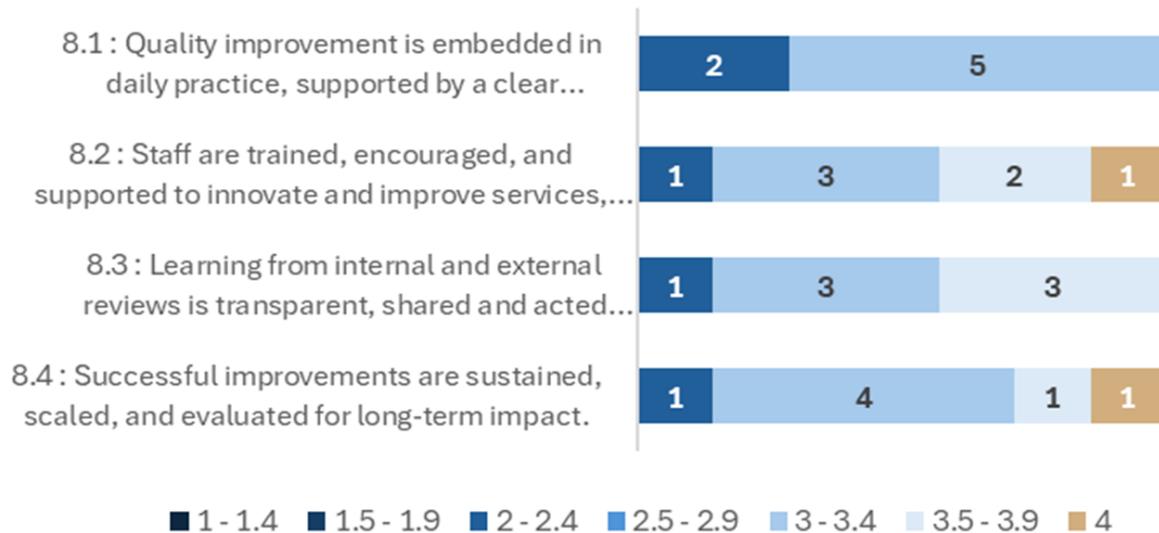
Appendix E: Governance, Commissioning questionnaire and additional questions

Section 1: Funding:

1. How is funding for maternity and neonatal services agreed and allocated for each health board? (including block grants and project funding)

2. What proportion of the overall health budget in Wales has been spent on maternity and neonatal services in each year in this Senedd term?

3. How are financial imbalances resulting from cross-border care accounted for? (cross-border to include health boards and trusts in Wales and England).

4. What additional national maternity and neonatal programmes have been funded in this Senedd term, and how was the funding distributed?

5. In funding decisions related to maternity and neonatal services, how are changing needs such as increased complexity of care, evidence re. services that should and should not be provided, and population factors such as health needs, socio-economic deprivation, and geography etc taken into account?

6. What is the budget for specialist maternity and neonatal services, commissioned by the JCC, and how has this changed over the last five years?

7. Please explain briefly the budget/service planning processes – in health boards, and in your national organisation.

Section 2: Quality and safety

8. How are you assured that quality services are being provided?

    a. What data and reports do you receive from health boards regarding quality of maternity and neonatal care and what is the time lag between the delivery of services and your monitoring of that data?

    b. How are the experiences of women, partners, staff and students incorporated into your assessments of quality?

    c. How do you respond to any quality issues identified, and within what timeframe?

9. How are you assured that safe services are being provided in maternity and neonatal care?

    a. What data and reports do you receive from health boards regarding safety and what is the time lag between the delivery of services and your monitoring of that data?

    b. How are the experiences of women, partners, staff and students incorporated into your assessments of safety?

    c. How do you respond to any safety issues identified?

10. How is consistency of quality and safety across health boards assured?

11. What are the strengths in the current lines of accountability, and where would you like to see improvement in the lines of accountability?

    a. How do you work with Health Boards to either encourage or require improvement or innovation?

    b. Please comment on the inter-relationships and flow of information between national bodies. How do these enable you to carry out your responsibilities, and what could be improved? You may wish to give a specific example, such as the IMPT process, to illustrate this.

12. How are health boards and families involved in national policy development in maternity and neonatal services?

13. How are litigation costs allocated?

    a. What relationship is there between quality of care and allocation of litigation costs?

Section 3: Education

14. What is the relationship between service commissioning and education commissioning – for a) under-graduate or b) post-graduate education and CPD?

    a. What is the mechanism for this?

    b. How is effectiveness and value for money of education commissioning in relation to service provision determined.

Section 4: The commissioning system

15. Please explain how commissioning works in maternity and neonatal services in Wales.

    a. a. What are the strengths and weaknesses of the current commissioning system?

Additional open text questions for Board:

- Do you have a vision and strategy specifically for your maternity and neonatal service? How was this developed and who was involved (partners and all stakeholders).
  - » Does this vision and strategy capture sustainability factors (financial, quality or both) associated with its effective delivery.
  - » How does your maternity and neonatal vision and strategy take account of the risks associated with the risks, such as geographical provision of maternity and neonatal services; considering the models of care associated geographical risk and workforce modelling (isolation and activity)
  - » How does this vision and strategy consider the evolution of maternity and neonatal care provision and the associated workforce modelling or strategic risks?
  - » How often is this strategy reviewed following approval; what triggers a review and when was the last review completed?
- How does Maternity and Neonatal services feed into the Board Assurance Framework and management of risk processes? How is the Board assured that it has a clear line of sight to maternity and neonatal services *(are there multiple layers of committees between the Board and those with day-to-day responsibility? Is there a service manager with knowledge of current practice in the room for all discussions about maternity?)*

- How is the Board assured that:

  » escalation processes are robust, both internally within the Health Board and externally with wider partners and regulators.

  » o once escalated the necessary response and actions are triggered and acted upon, both internally within the Health Board and externally with wider partners and regulators.

  » · What maternity and neonatal outcomes do the Board monitor and with what frequency? What actions have resulted from monitoring outcomes?

- When did the Board last have a substantive discussion about maternity services, what was discussed and what actions resulted?

- Who on the Board has a lead for the maternity services? How regularly do members of the board (executive and non-executive) visit maternity services, when did they last conduct a site visit and what were the outcome of the visit(s)?

- At what level of seniority is the most senior midwife appointed and what service areas does that role cover in terms of responsibility and oversight?

- When was the last time the Health Board proactively requested external input or peer review and how does the Health Board embrace peer review comparisons to consider the effectiveness and safety of their own maternity and neonatal service? Please provide examples.

- What is your process for Quality Impact Assessments, by whom and what decision regarding maternity services have you not taken as a result of a QIA?

- How are you assured where matters of conduct (racism; bullying; sexual-discrimination; harassment etc) are raised they are appropriately managed? And what is your longest outstanding disciplinary?

Additional open text questions for Director of Midwifery/ Head of Neonatal Service:

- How are you assured maternity and neonatal services are planned and delivered to take account of people with different needs, including but not limited to: ethnicity, socio-economic, geographical, disability, sexual orientation or gender? How are you risk-assessing at each element of the person's journey to take account of inequalities?

- How and who reviews national guidance and alerts to ensure it is relevant and where necessary, applied across your services?

- What cross organisational meetings does the DoM/HoM attend to ensure perinatal services are recognised and a core part of the overall Health Board and not stand alone?

- What most concerns you about your service at the moment? What changes would help most?

- What are you most proud of about your service?

-

Appendix F: Supplementary data

Figure 1: Map of Welsh Index of Multiple Deprivation (WIMD), Wales, 2025.

© Crown copyright 2025. Cartographics. Welsh Government.
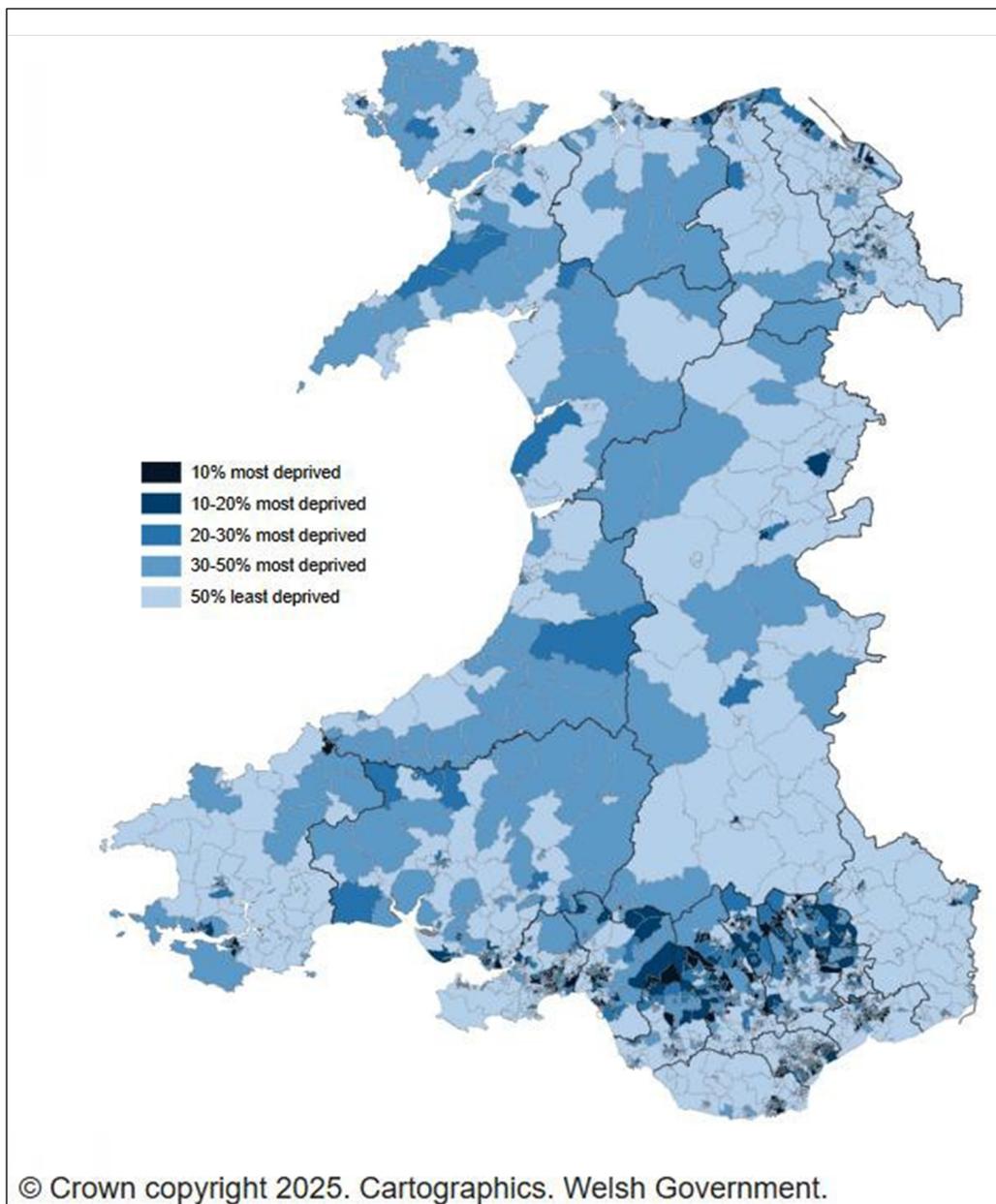
Figure 2: Midwifery headcounts and FTE in Wales, March 2015-March 2025.

Headcounts and full-time equivalents

Midwifery Headcount and FTE
— Headcount — FTE

	Mar 2015	Mar 2016	Mar 2017	Mar 2018	Mar 2019	Mar 2020	Mar 2021	Mar 2022	Mar 2023	Mar 2024	Mar 2025
Headcount	1,708	1,747	1,802	1,770	1,781	1,809	1,819	1,822	1,813	1,890	1,961
FTE	1,425.0	1,469.8	1,507.1	1,479.6	1,484.3	1,520.3	1,537.1	1,527.5	1,506.4	1,558.6	1,614.6
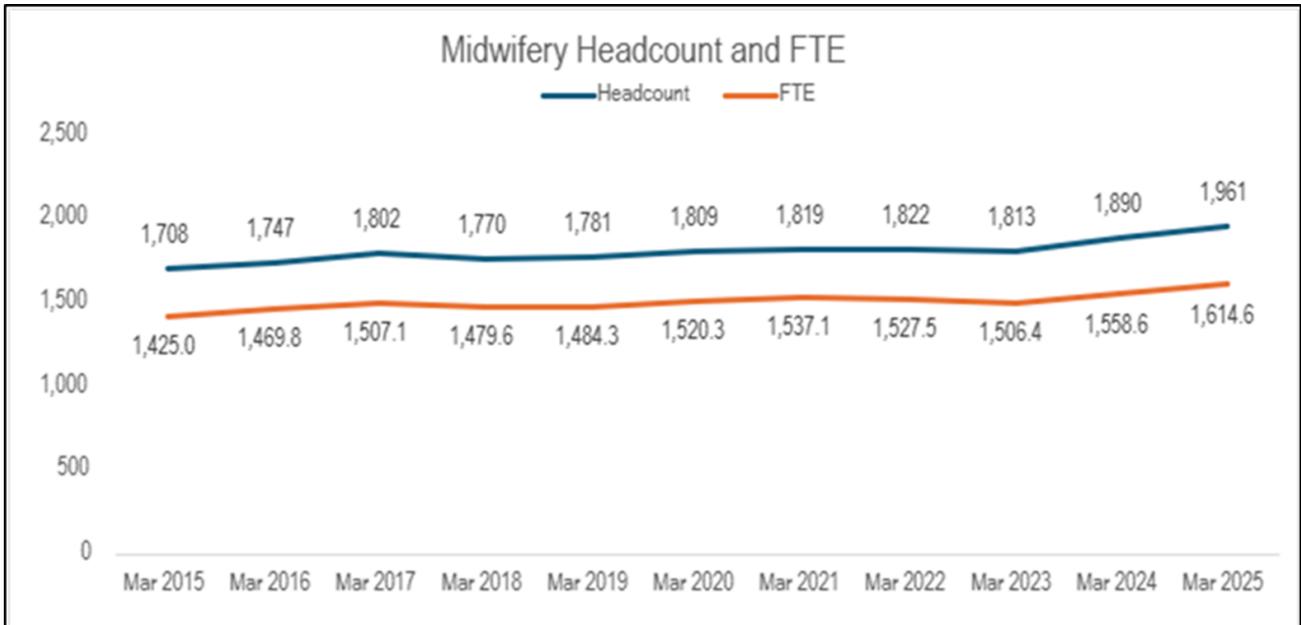
Source: Health Education and Improvement Wales (HEIW).

Figure 3: Midwifery FTE in Wales, by age band, March 2015 and March 2025.

Full time equivalent by age band
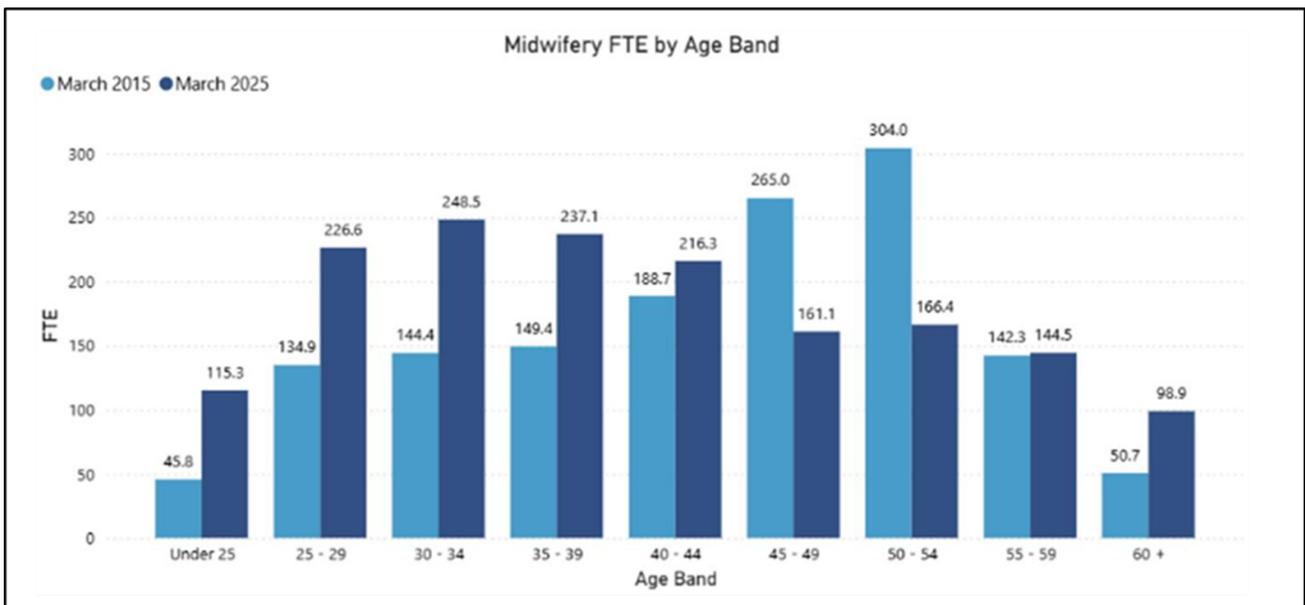
Midwifery FTE by Age Band
● March 2015 ● March 2025

Age Band	March 2015	March 2025
Under 25	45.8	115.3
25 - 29	134.9	226.6
30 - 34	144.4	248.5
35 - 39	149.4	237.1
40 - 44	188.7	216.3
45 - 49	265.0	161.1
50 - 54	304.0	166.4
55 - 59	142.3	144.5
60 +	50.7	98.9

Source: Health Education and Improvement Wales (HEIW).

Figure 4: Number of midwives commissioned in Wales, 2016-2025.

Commissioned student midwife places
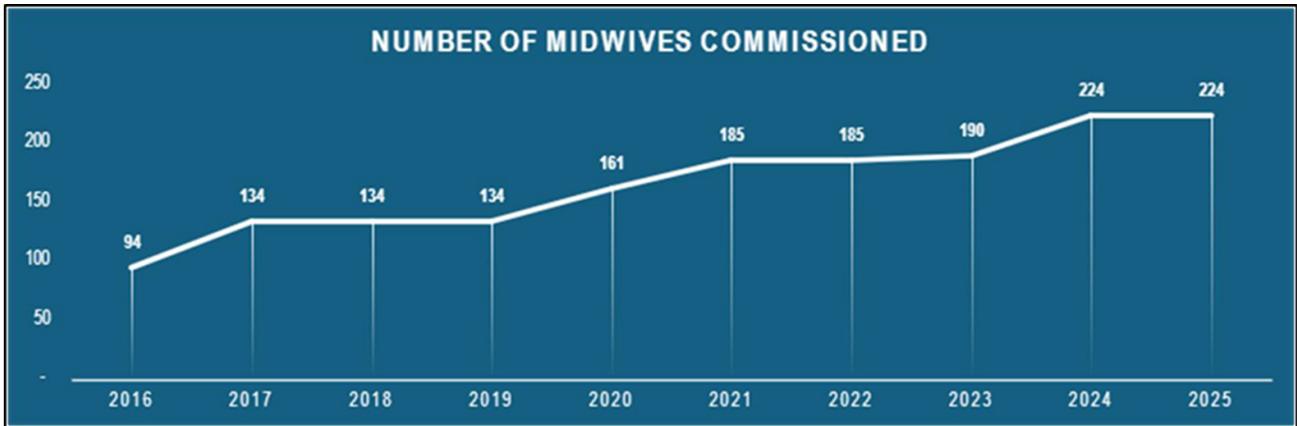
Source: Health Education and Improvement Wales (HEIW).

Figure 5: Midwives monthly sickness rates, Wales, January 2018- July 2025.

Sickness rates
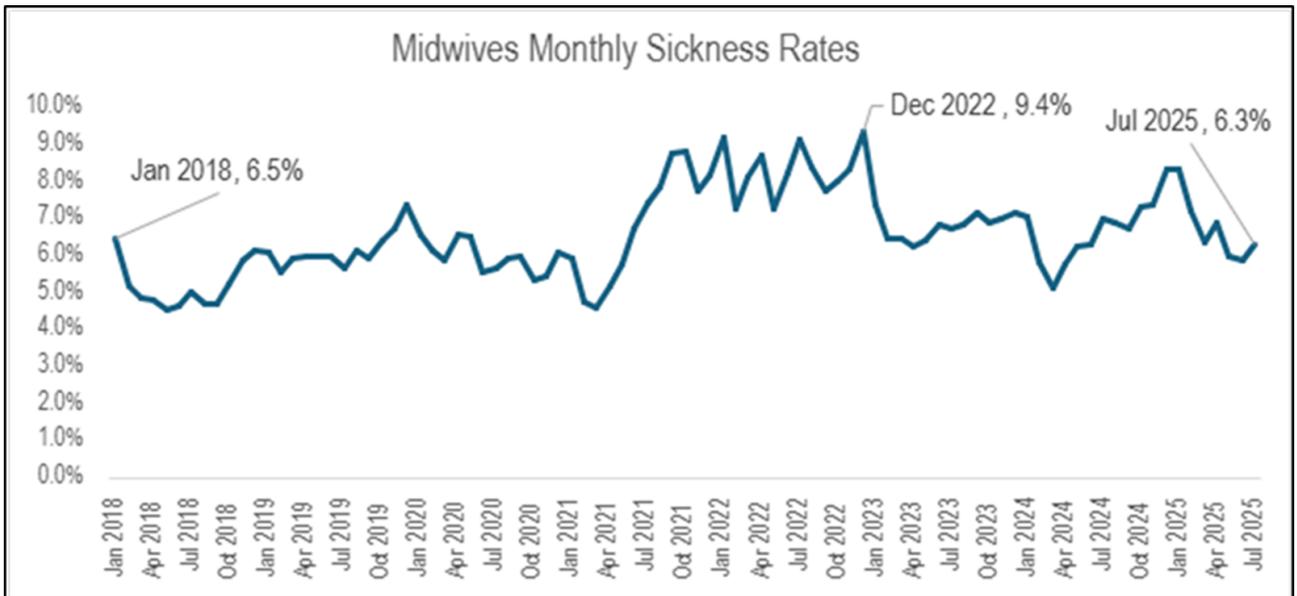
Source: Health Education and Improvement Wales (HEIW).

Table 1: Midwifery sickness reasons in Wales, 2024/25

Reason for sickness	Proportion of sickness days (%)
Anxiety / stress / depression / other psychiatric illnesses	37.55
Cold, cough, flu-influenza	8.25
Gastrointestinal problems	6.23
Other musculoskeletal problems	5.92
Genitourinary & gynecological disorders	5.70
Pregnancy related disorders	5.47
Other known causes - not elsewhere classified	5.00
Injury, fracture	4.71
Back problems	3.45
Heart, cardiac & circulatory problems	3.35
Chest and respiratory problems	2.96
Headache / migraine	2.09
Unknown causes / not specified	2.09
Benign and malignant tumors, cancers	1.63
Ear, nose, throat (ENT)	1.47
Skin disorders	1.05
Nervous system disorders	0.99
Endocrine/glandular problems	0.54
Infectious diseases	0.53
Eye problems	0.49
Dental and oral problems	0.27
Blood disorders	0.22
Asthma	0.01
Burns, poisoning, frostbite, hypothermia	0.01

Source: Health Education and Improvement Wales (HEIW).

Note: For financial year 24/25 the most common sickness reason for Midwives was 'Anxiety/stress/depression/other psychiatric illnesses' accounting for 37.55% of sickness days

Figure 6: Neonatal nursing headcounts and FTE in Wales, March 2015-March 2025.
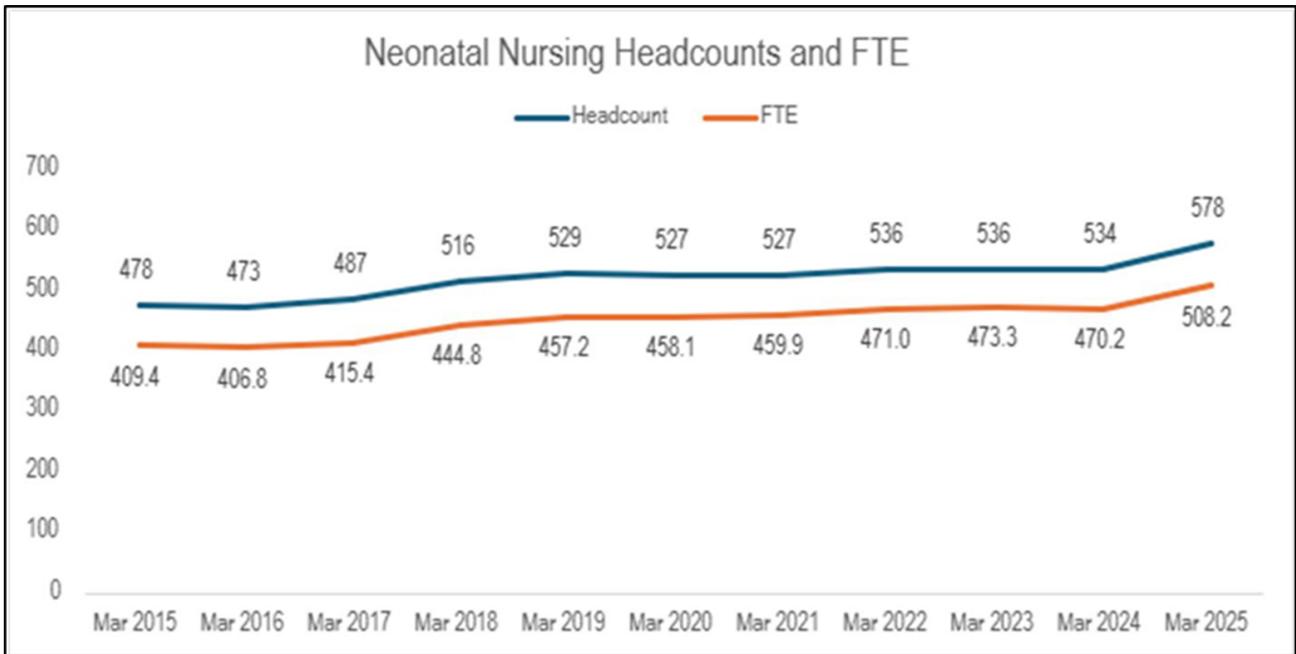
Source: Health Education and Improvement Wales (HEIW).

Figure 7: Neonatal nursing FTE in Wales, by age band, March 2015 and March 2025.
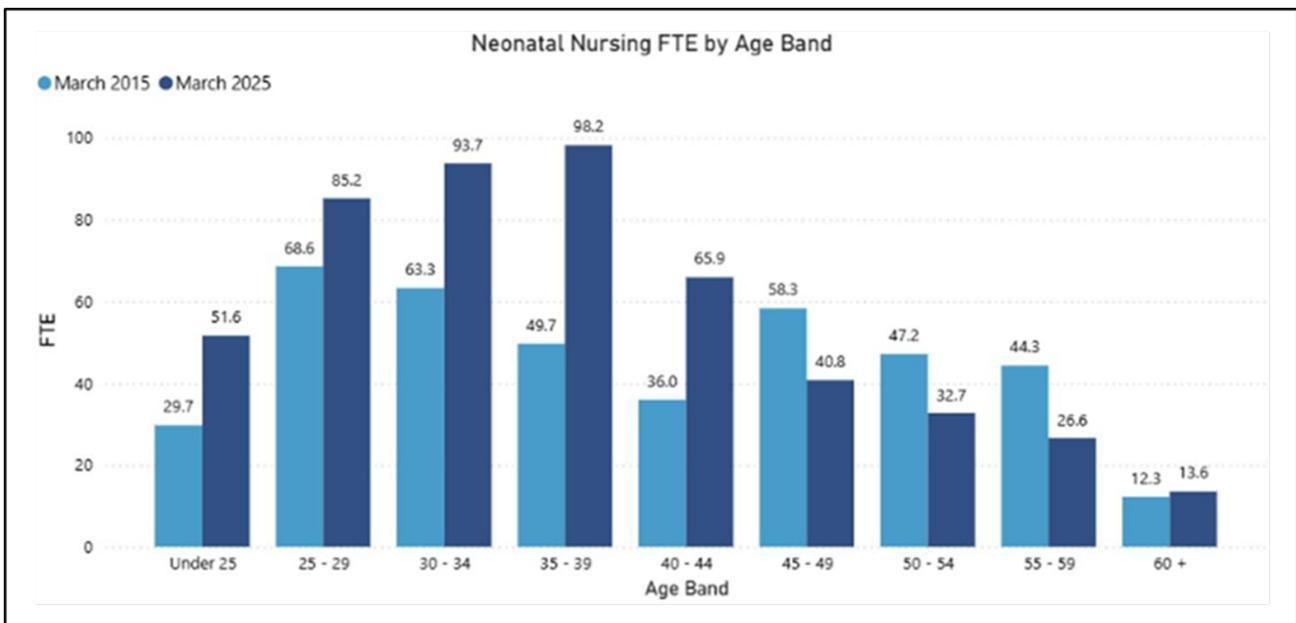
Source: Health Education and Improvement of Wales (HEIW).

Figure 8: Neonatal nurses monthly sickness rates, Wales, January 2018-July 2025.
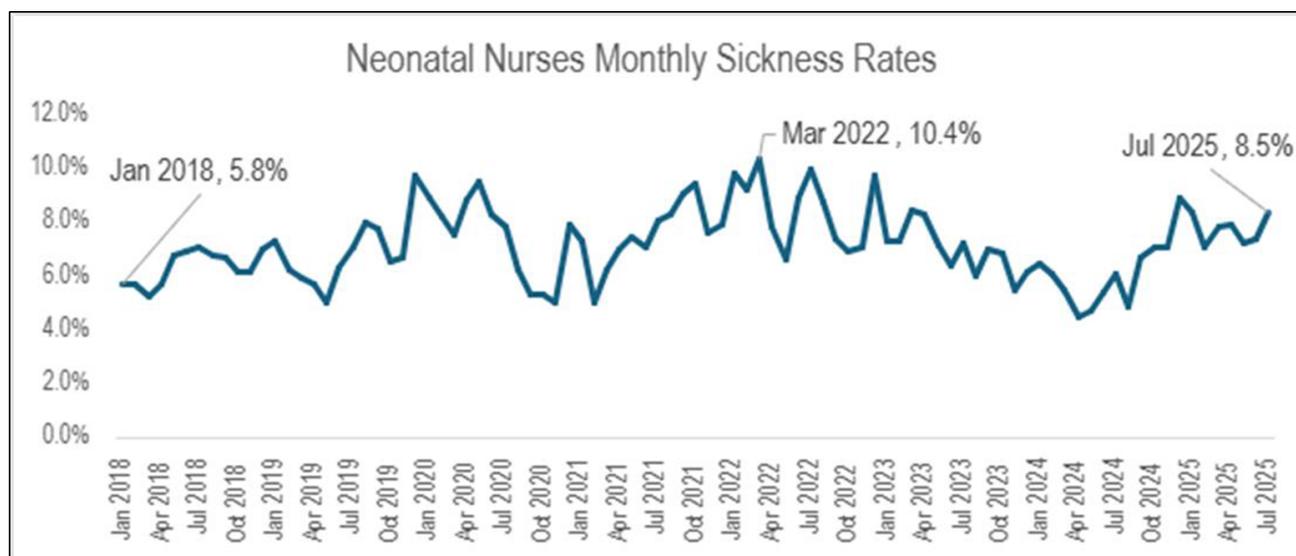
Source: Health Education and Improvement Wales (HEIW).

Table 2: Neonatal nursing sickness reasons in Wales, 2024/25.

Reason for sickness	Proportion of sickness days (%)
Anxiety / stress / depression / other psychiatric illnesses	38.23
Pregnancy related disorders	9.13
Other musculoskeletal problems	8.96
Cold, cough, flu-influenza	8.70
Other known causes - not elsewhere classified	5.41
Gastrointestinal problems	5.25
Injury, fracture	5.00
Ear, nose, throat (ENT)	3.08
Chest and respiratory problems	2.98
Back problems	2.38
Headache/migraine	2.37
Genitourinary & gynecological disorders	1.67
Heart, cardiac & circulatory problems	1.53
Unknown causes/not specified	1.39
Infectious diseases	1.29
Eye problems	1.25
Benign and malignant tumors, cancers	0.41

Reason for sickness	Proportion of sickness days (%)
Skin disorders	0.31
Blood disorders	0.30
Dental and oral problems	0.19
Asthma	0.09
Endocrine/glandular problems	0.08

Source: Health Education and Improvement Wales (HEIW).

Note: For financial year 24/25 the most common sickness reason for Neonatal Nurses was 'Anxiety/stress/depression/other psychiatric illnesses' accounting for 38.23% of sickness days.

Table 3: PROMPT compliance by health board, 01/09/24-31/08/25

Intrapartum Fetal Surveillance (IFS)

Health board	Compliance (%)
Aneurin Bevan University Health Board	97.0
Betsi Cadwaladr University Health Board	88.5
Cardiff and Vale University Health Board	97.0
Cwm Taf Morgannwg University Health Board	89.0
Hywel Dda University Health Board	88.5
Powys Teaching Health Board	100
Swansea Bay University Health Board	97.0

Source: Welsh Risk Pool, NHS Wales Shared Services Partnership (NWSSP).

Table 4: Intrapartum Fetal Surveillance (IFS) by health board, 01/09/24-31/08/25

Health board	Compliance (%)
Aneurin Bevan University Health Board	97.5
Betsi Cadwaladr University Health Board	80.5
Cardiff and Vale University Health Board	91.5
Cwm Taf Morgannwg University Health Board	83.5
Hywel Dda University Health Board	90.5
Powys Teaching Health Board	91.0
Swansea Bay University Health Board	98.0

Figure 9: Number of pregnancies by parity, Wales, 2016-2024.
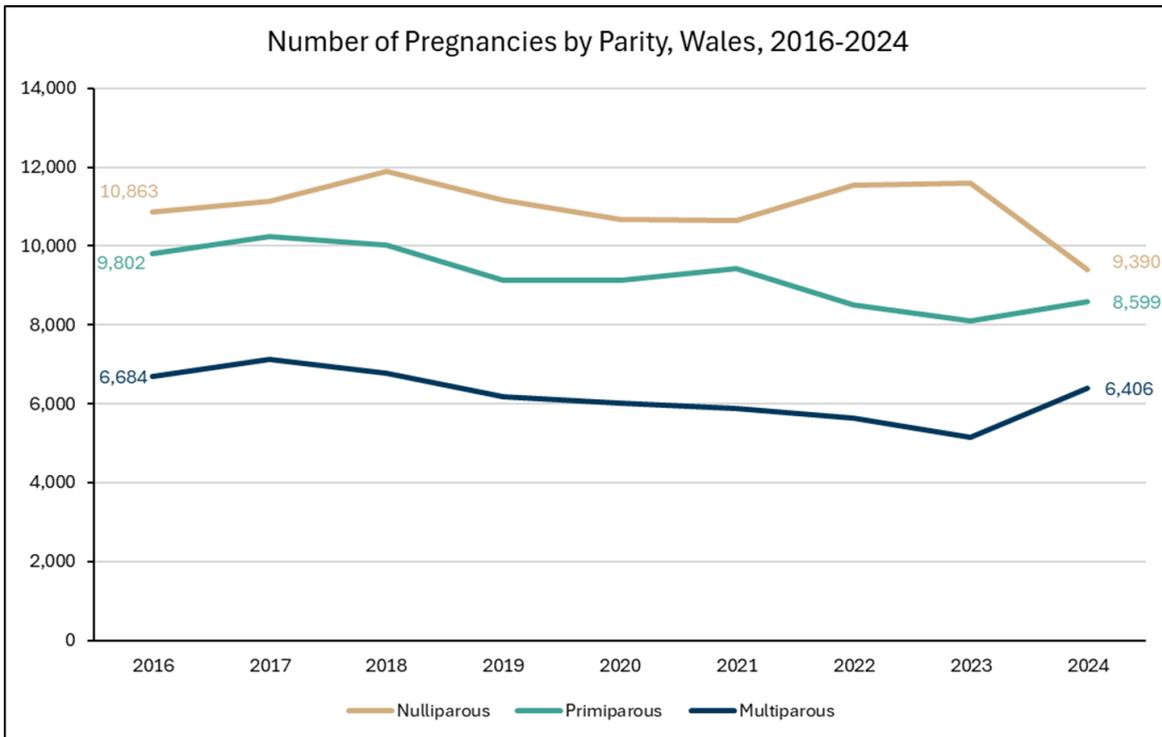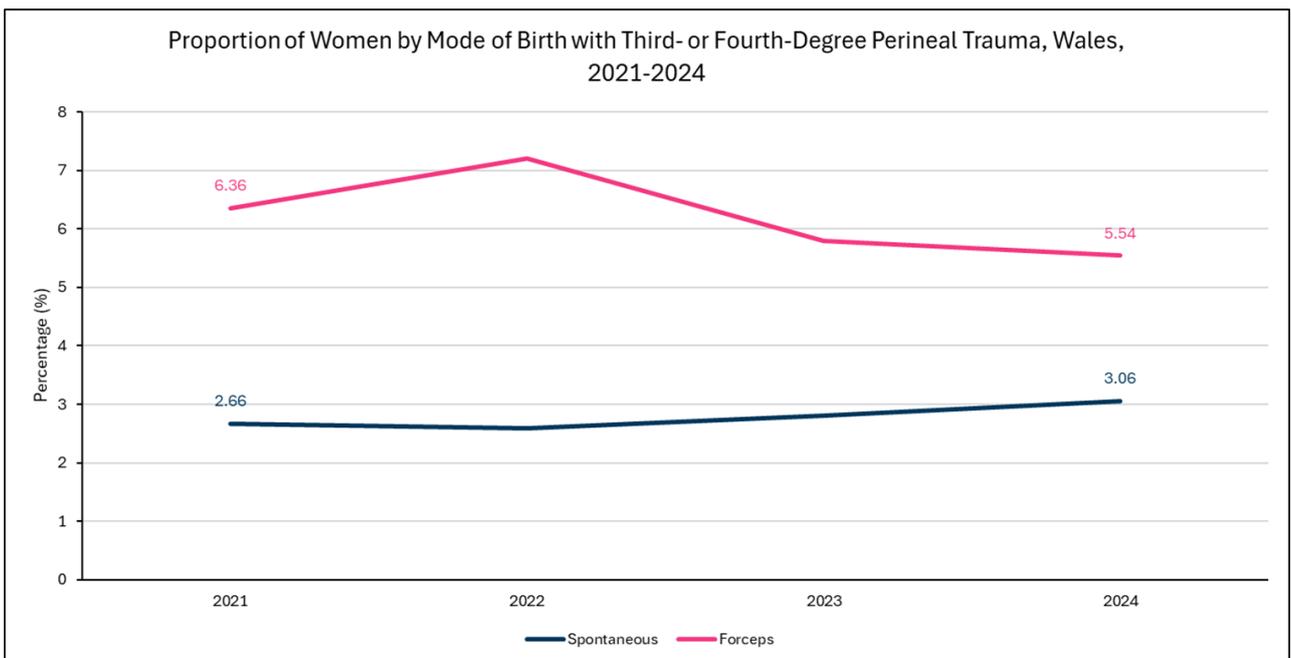

Number of Pregnancies by Parity, Wales, 2016-2024

Source: Maternity Indicators Dataset (MIDS) - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

Figure 10: Proportion of births in Wales, by mode of onset of labour, 2016-2023

Proportion of Births in Wales, by Mode of Onset of Labour, 2016-2023

Source: Maternity Indicators Dataset (MIDS).
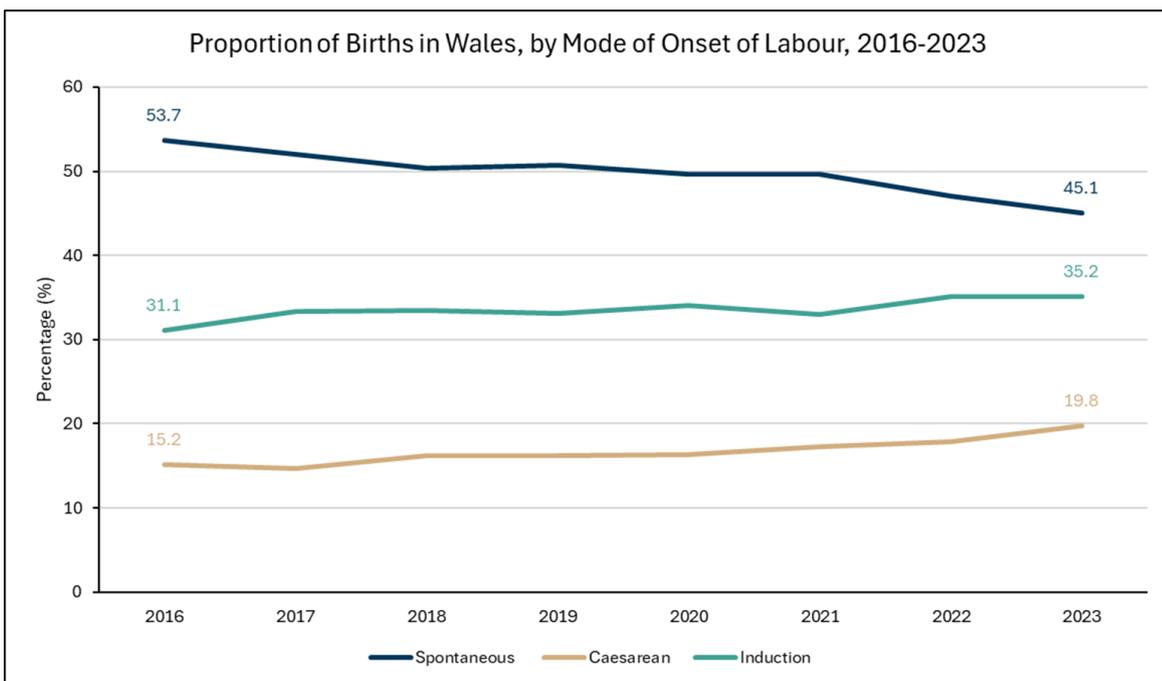
Figure 11: Proportion of births in Wales, by mode of birth, 2016-2023.

Proportion of Births in Wales, by Mode of Birth, 2016-2023
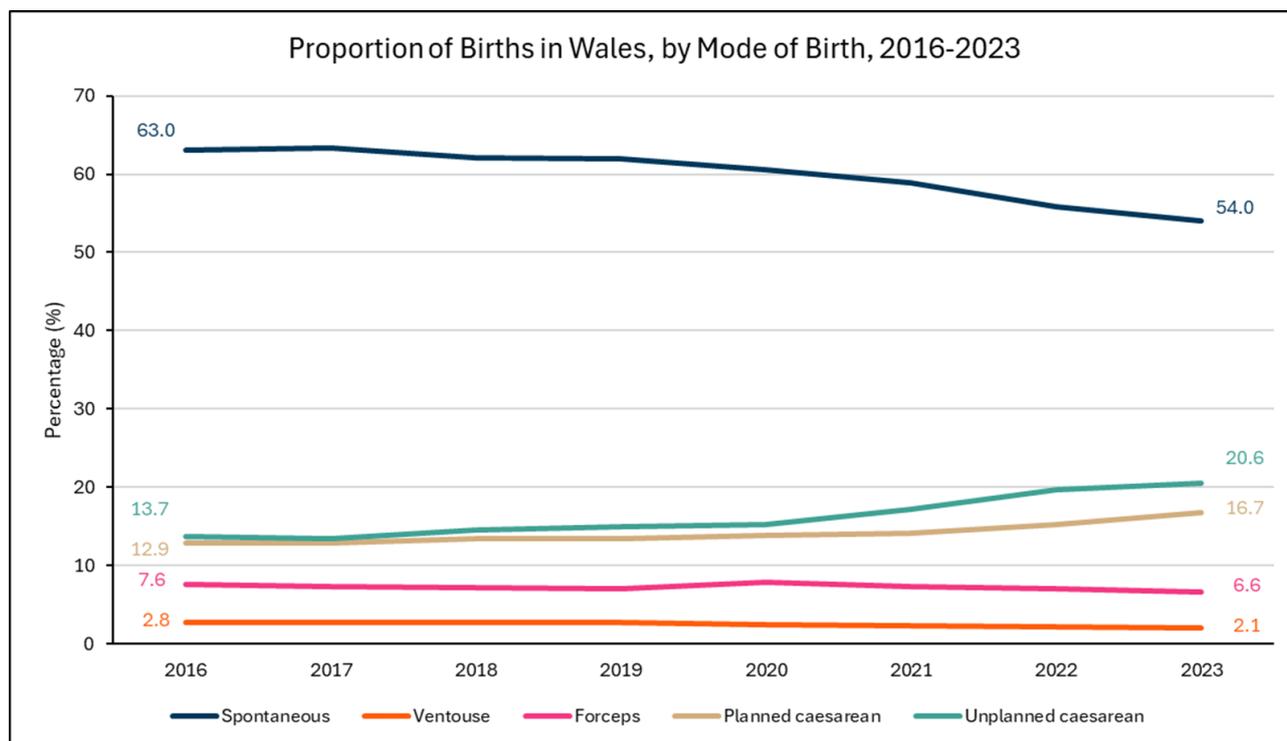
Source: Maternity Indicators Dataset (MIDS).

Note: Data for 2024 has been excluded from this analysis due to reliability concerns. During 2024, StatsWales was unable to publish data for Aneurin Bevan University Health Board because of issues arising from the transition to the BadgerNet® Maternity digital system.

This limitation does not affect analyses completed by the NHS Wales Performance & Improvement Data & Analytics team, as the team had access to a timelier dataset that has since been updated and corrected.

Figure 12: Proportion of births in Wales by mode of birth and deprivation quintile, 2024.
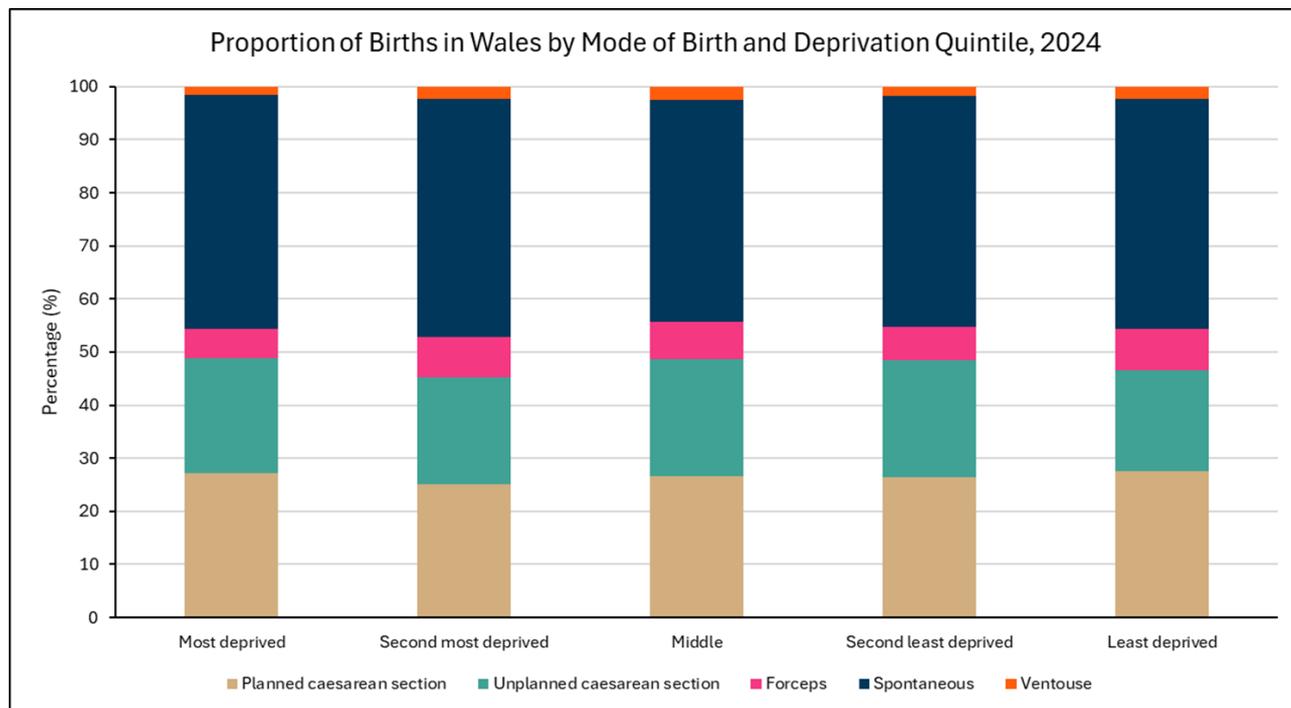
Proportion of Births in Wales by Mode of Birth and Deprivation Quintile, 2024

Source: Maternity Indicators Dataset (MIDS) - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

Figure 13: Number of pregnancies by parity and mode of birth, Wales, 2024.

Number of Pregnancies by Parity and Mode of Birth, Wales, 2024
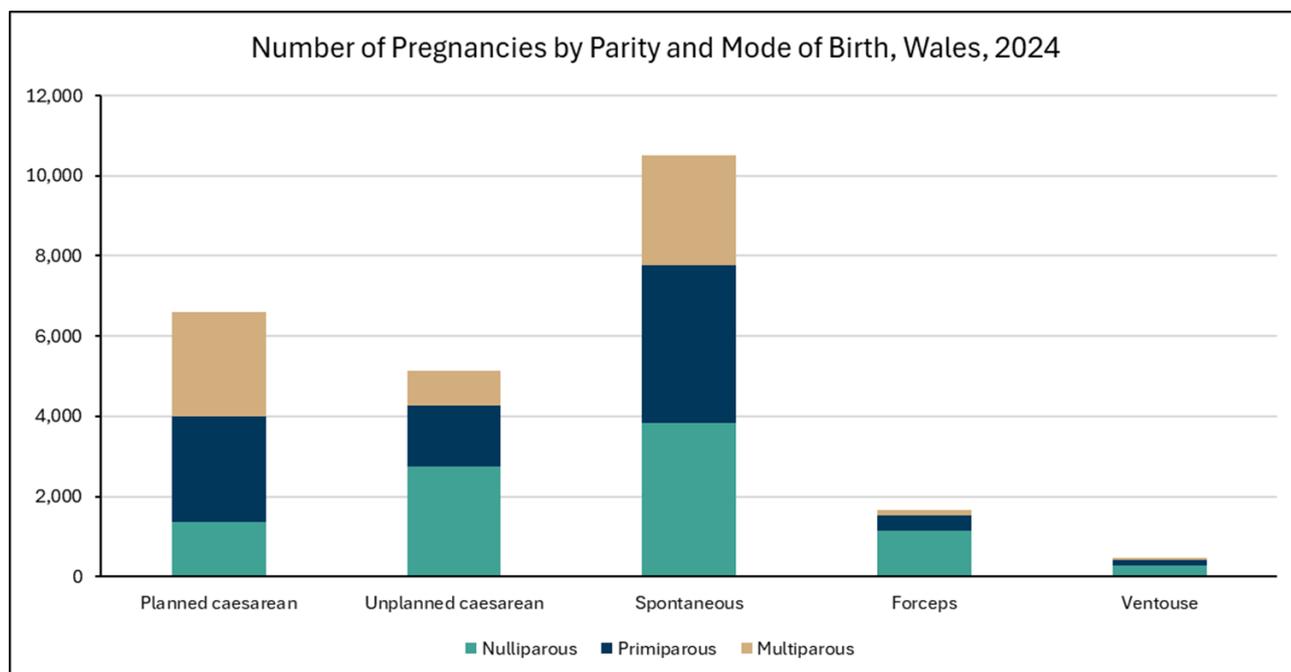
Source: Maternity Indicators Dataset (MIDS) - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

Figure 14: Caesarean surgical site infection rate in Wales, 2023-2024.

Source: Healthcare Associated Infection, Antimicrobial Resistance & Prescribing Programme (HARP), Public Health Wales (PHW).

Figure 15: Proportion of women by mode of birth with third- or fourth-degree perineal trauma, Wales, 2021-2024.

Source: Maternity Indicators Dataset (MIDS) - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

Figure 15 Note(s): Data on women experiencing third- or fourth-degree perineal trauma has been restricted to the years 2021 to 2024 due to data quality limitations in earlier periods. Records prior to 2021 were found to be inconsistent or incomplete and therefore excluded from this analysis to ensure accuracy and reliability.

Ventouse-assisted births have been excluded from this analysis due to extremely low numbers, which raise concerns about data validity.

Percentages are calculated within each category of births. The denominator reflects the number of births in that specific category, not the total births across all categories.

Figure 16: HIE (grade 2 or 3) rate per 1,000 live births, Wales, 2021-2024.

HIE (Grade 2 or 3) rate per 1,000 Live Births, Wales, 2021-2024
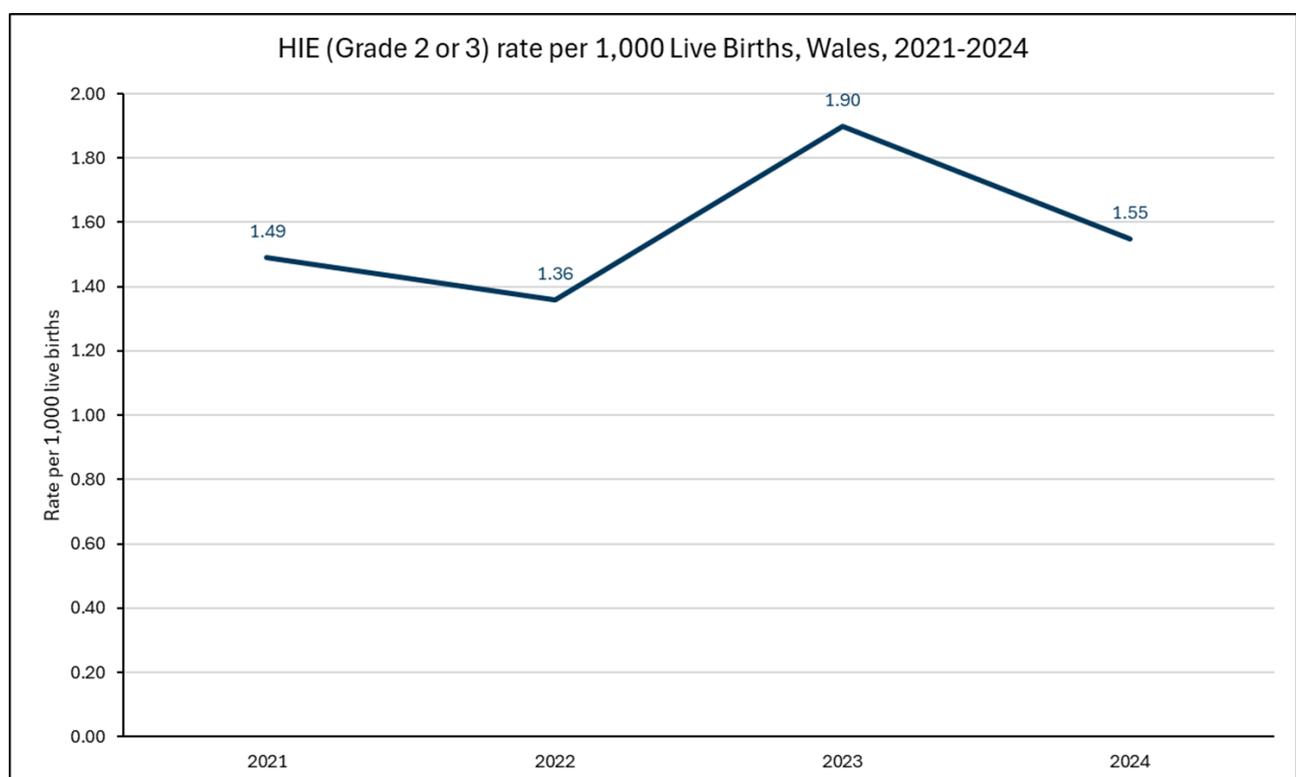
Source: BadgerNet® neonatal – data extracted & analyzed by NHS Wales Performance & Improvement Data & Analytics team

Figure 17: Proportion of mothers who were breastfeeding in Wales, by age of baby, 2016-2024.
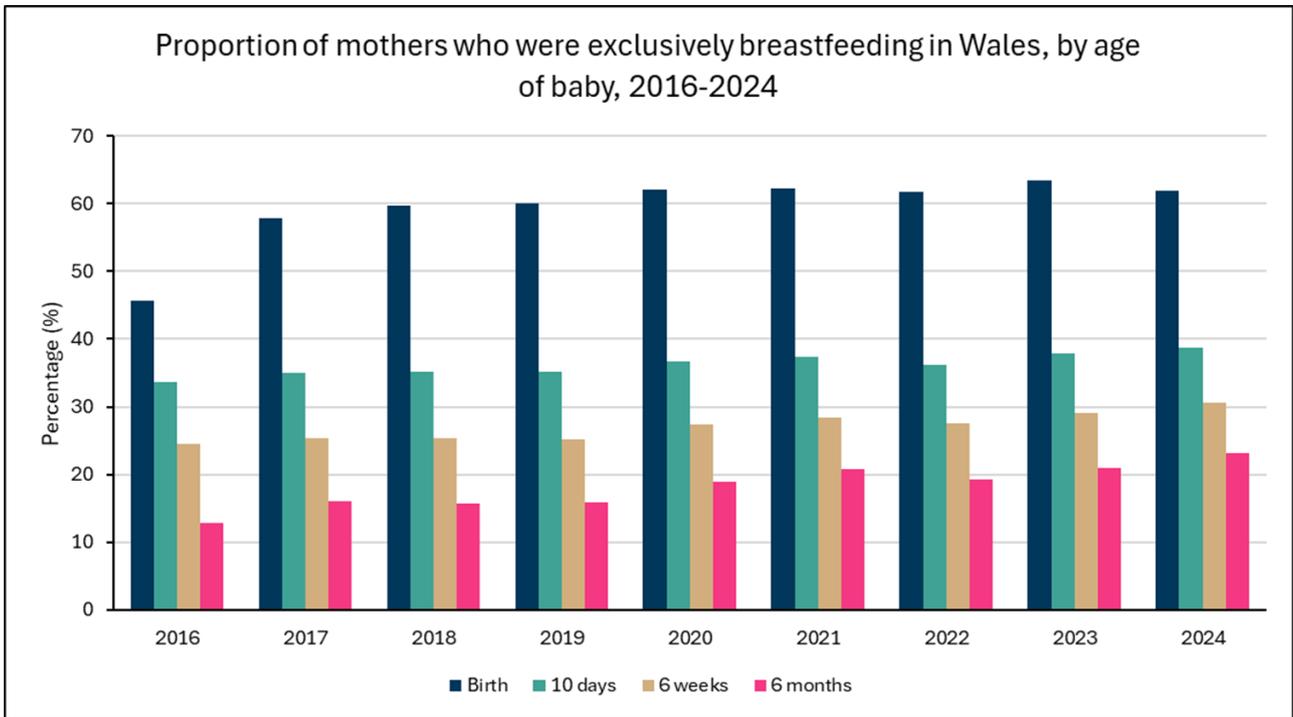
Source: National Community Child Health Database (NCCHD).

Figure 18: Proportion of mothers who were exclusively breastfeeding in Wales by deprivation quintile, 2019-2024.
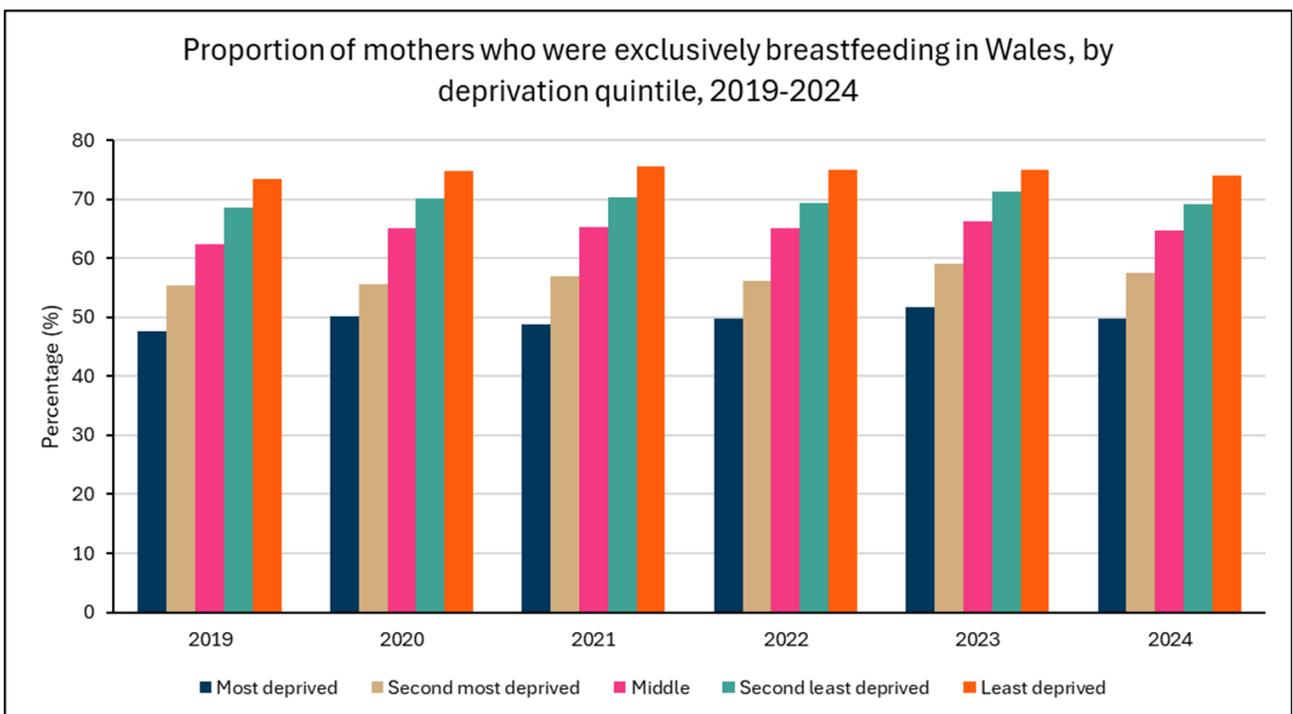
Source: National Community Child Health Database (NCCHD).

Figure 19: Proportion of mothers who were breastfeeding in Wales by ethnic group, 2024.
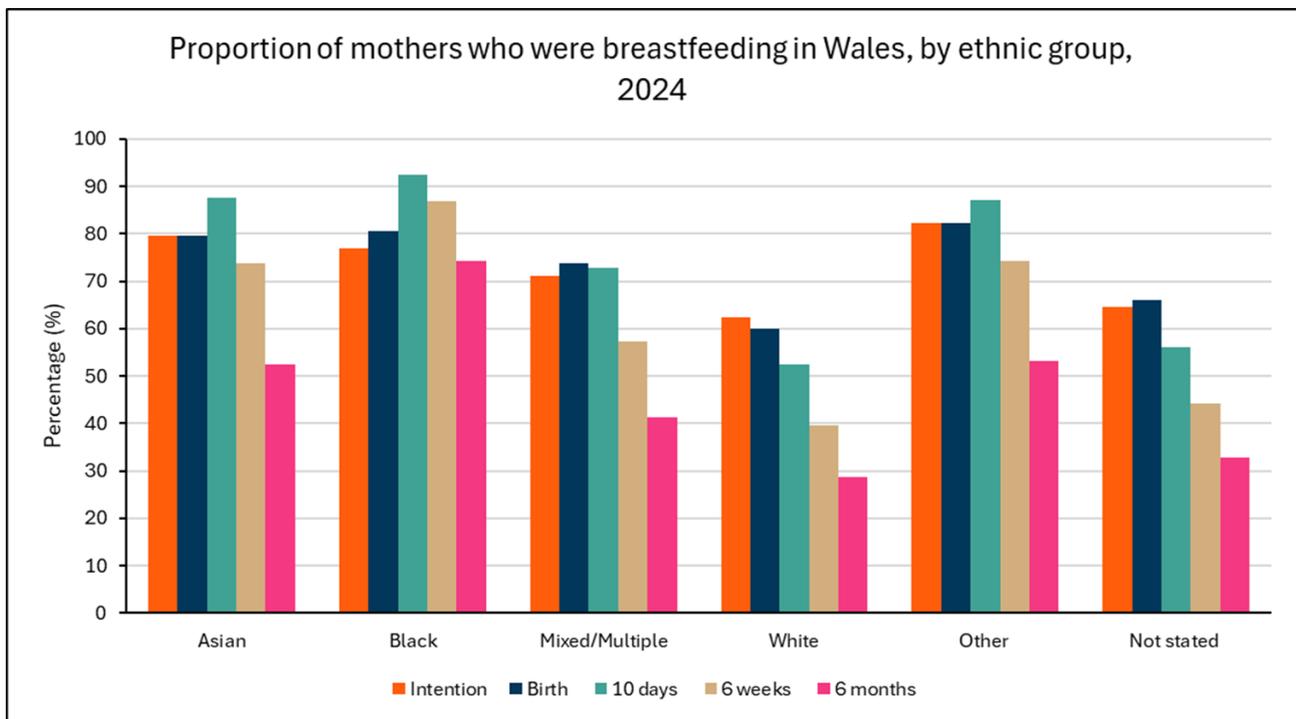
Proportion of mothers who were breastfeeding in Wales, by ethnic group, 2024

Figure 20: Proportion of mothers who were breastfeeding in Wales, by age of mother, 2024.

Proportion of mothers who were breastfeeding in Wales, by age of mother, 2024
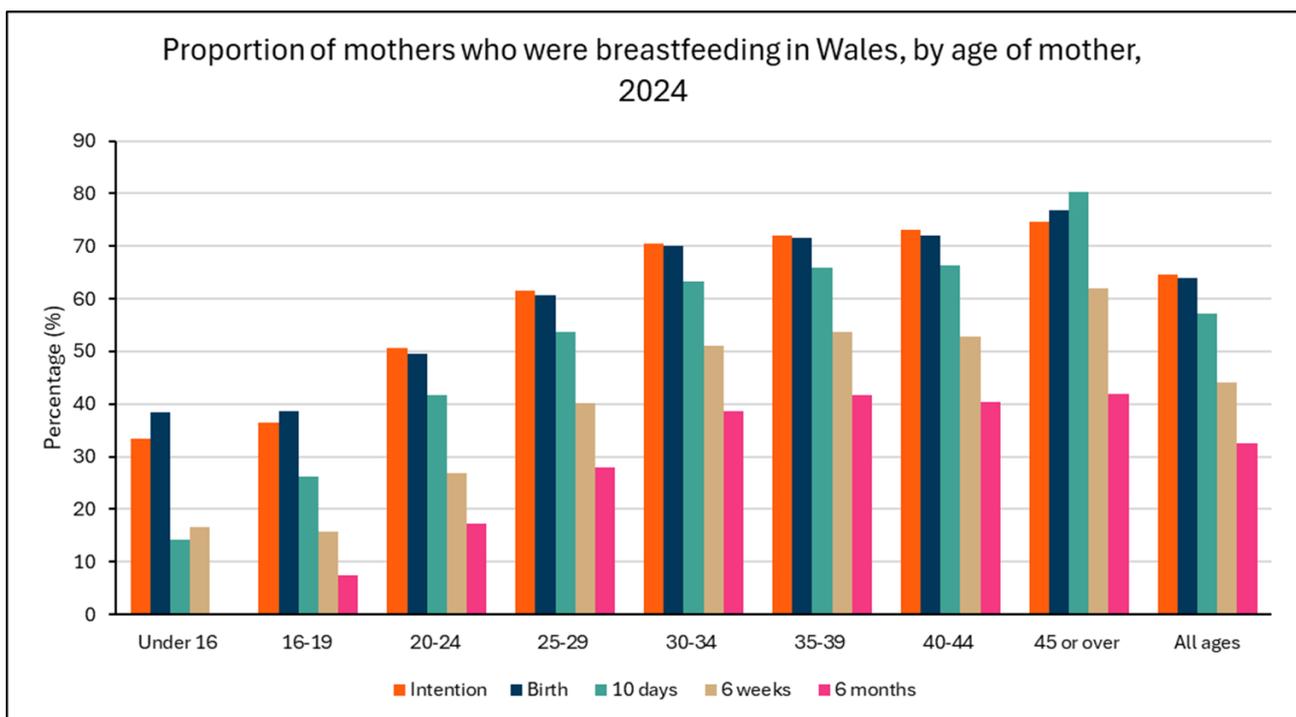
Note: Figures 62–69 present breastfeeding status corresponding to the scheduled postnatal assessments at 10 days, 6 weeks, and 6 months. In instances where the assessment occurs outside the designated timeframe, the recorded status should reflect the intended milestone (10-day, 6-week, or 6-month) rather than the actual date of the visit.

Figure 21: Proportion of women who were breastfeeding at 6 to 8 weeks, England, 2015/16 to 2024/25.

Proportion of Women who were Breastfeeding at 6 to 8 Weeks, England, 2015/16 to 2024/25
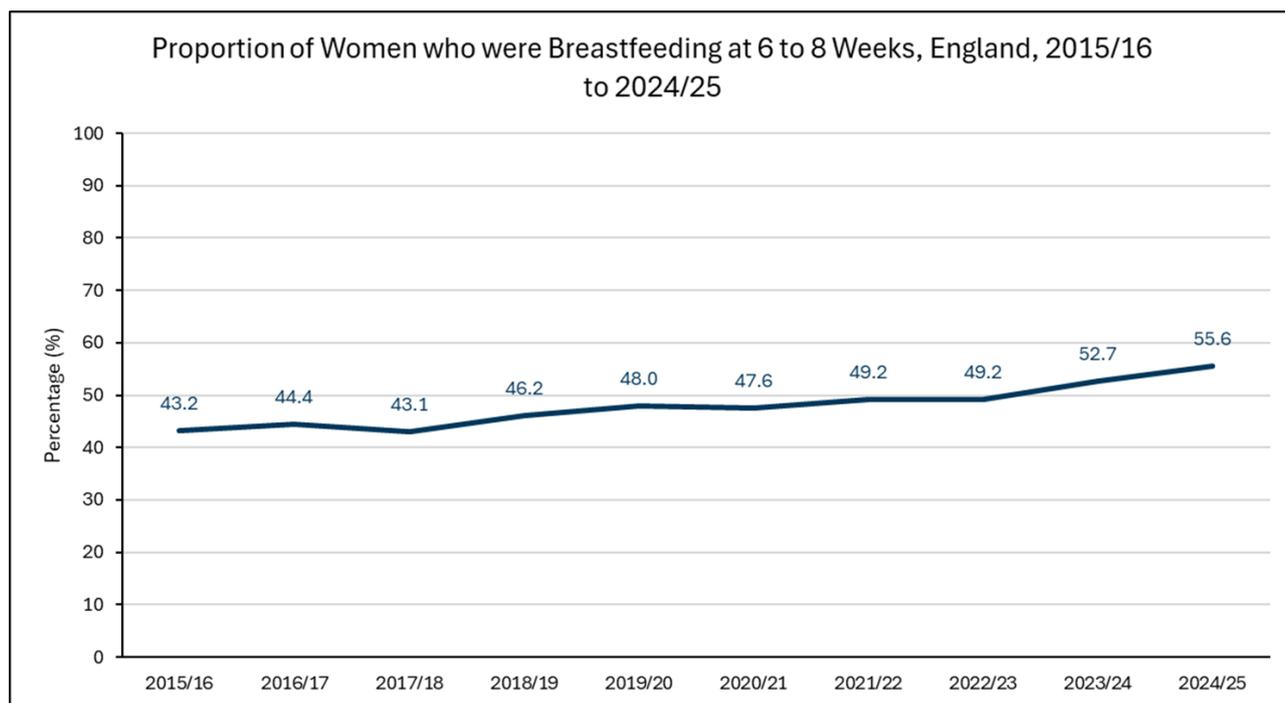
Source: Department of Health and Social Care.

Note: breastfeeding data for Wales and England are not directly comparable due to differences in definitions and reporting periods. In Wales, breastfeeding prevalence is measured at 6 weeks, whereas in England it is measured at 6 to 8 weeks. Additionally, England reports data by financial year, while Wales reports by calendar year. For this reason, the data for each country has been presented on separate charts, and these differences should be carefully considered when interpreting and comparing the figures.

Figure 22: Neonatal admissions per 1,000 live births, Wales, 2021-2024.
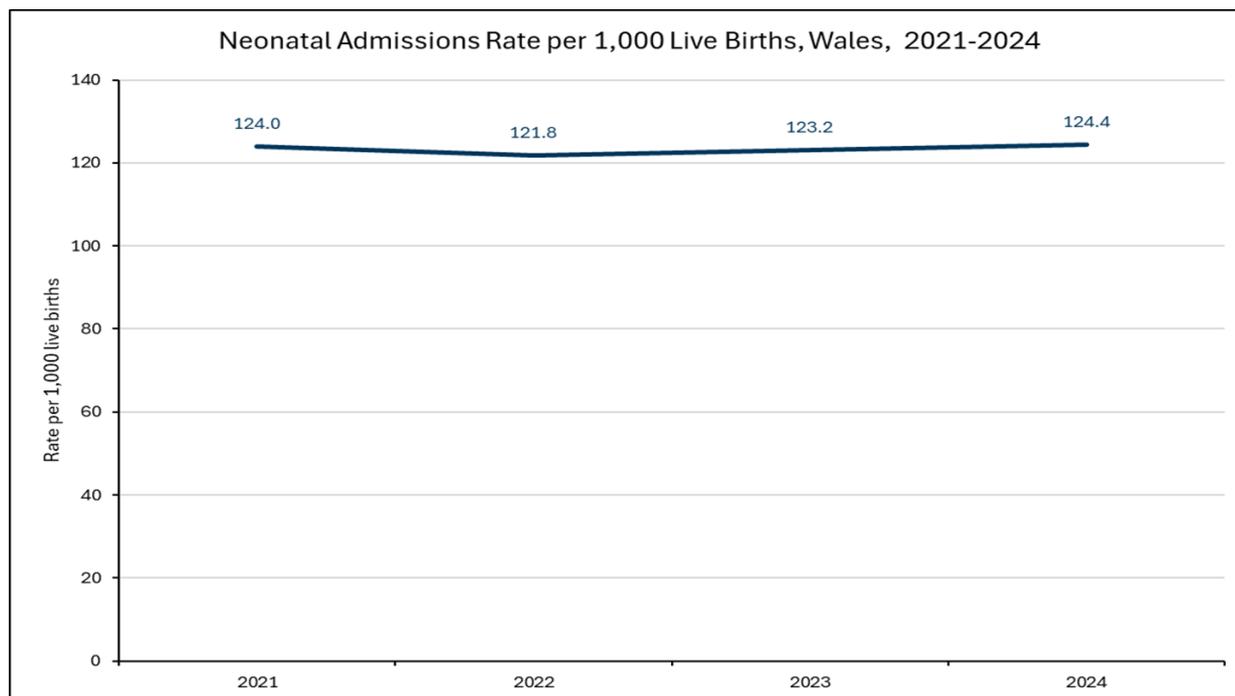
Neonatal Admissions Rate per 1,000 Live Births, Wales, 2021-2024

Source: BadgerNet® neonatal – data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

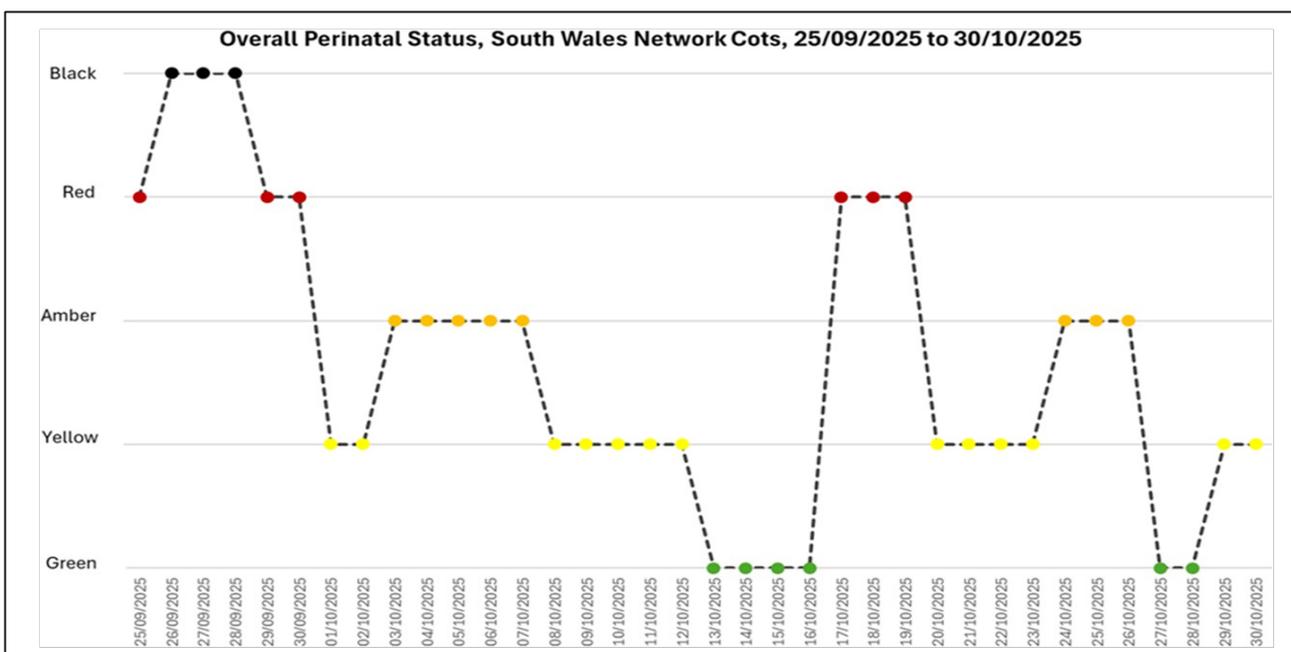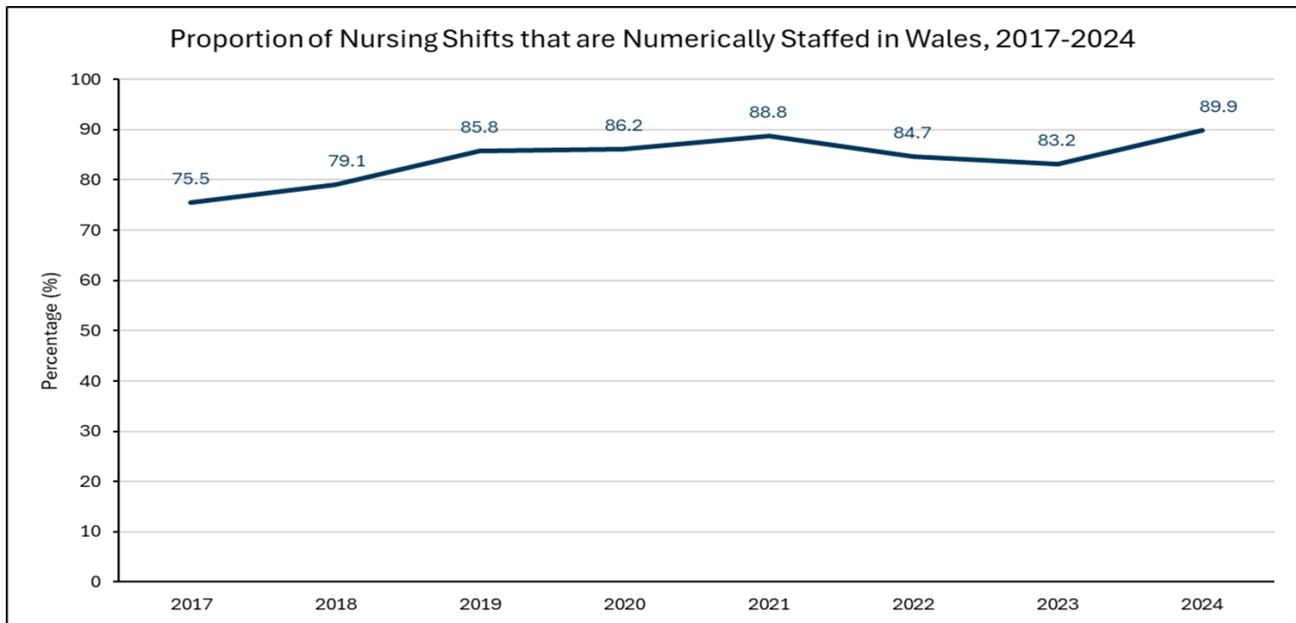**Figure 23: Number of neonatal admissions in Wales, 2021-2024.**

Number of Neonatal Admissions in Wales, 2021-2024

Source: BadgerNet® neonatal – data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

Figure 24: Neonatal Unit Term Admissions Rate per 1,000 Live Births, Wales, 2021-2024.

Source: BadgerNet® neonatal – data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

Figure 25: Overall perinatal status, South Wales Network cots, 25/09/2025 to 30/10/2025.

Source: South Wales Network cot locator - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

Figure 26: Proportion of nursing shifts numerically staffed in Wales, 2017-2024.

Proportion of Nursing Shifts that are Numerically Staffed in Wales, 2017-2024

Source: NNAP Restricted Access Dashboard

Note: Proportion of nursing shifts that are numerically staffed according to guidelines and service specifications.

Figure 27: NNAP overall neonatal network performance, Wales, 2024.
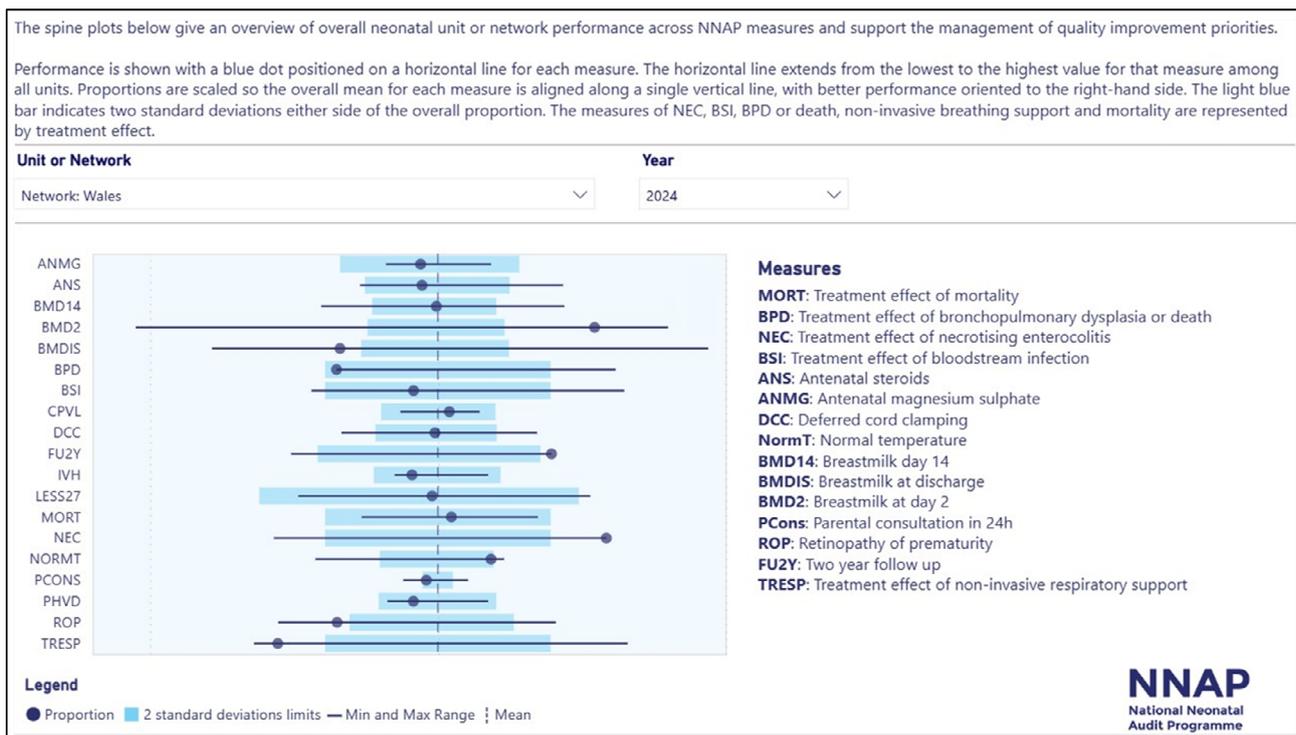
Source: National Neonatal Audit Programme (NNAP).

Note: Figure 27 gives a broad, high-level view of how Wales performs across the National Neonatal Audit Programme in comparison to other networks in England and across the UK using 2024 data.

The information highlights several areas where Wales as a network performed significantly better than other networks (2 standard deviations above the overall proportion) -

- Breastfeeding at day 2 of life (Babies born at less than 34 weeks gestational age receiving any of their own mother's milk in the first two days of life)

- Two-year follow up (Babies born at less than 30 weeks gestational age receiving a medical follow up at 2 years corrected age)

- Treatment effect of Necrotising enterocolitis (NEC) (Babies born at less than 32 weeks gestational age meets the NNAP definition for NEC on one or more occasion)

And several areas where Wales as a network performed significantly worse than other networks (2 standard deviations below the overall proportion)

- Breastfeeding on discharge (Babies born at less than 34 weeks gestational age receiving any of their own mother's milk at discharge to home from a neonatal unit)

- Retinopathy of prematurity screening (Babies born at less than 31 weeks gestational age, weighing less than 1501g at birth undergo the first ROP screening according to the guideline)

- Treatment effect of non-invasive respiratory support (Babies born at less than 32 weeks gestational age only receiving non-invasive breathing support during the first week of life).
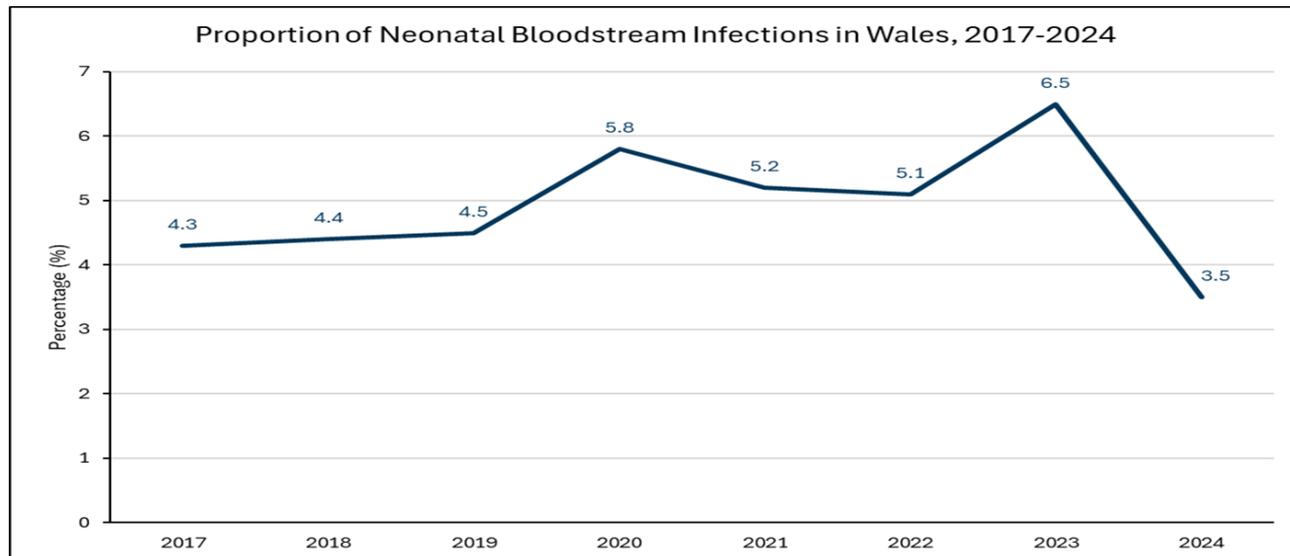
Figure 28: Proportion of deferred cord clamping in Wales, 2017-2024.
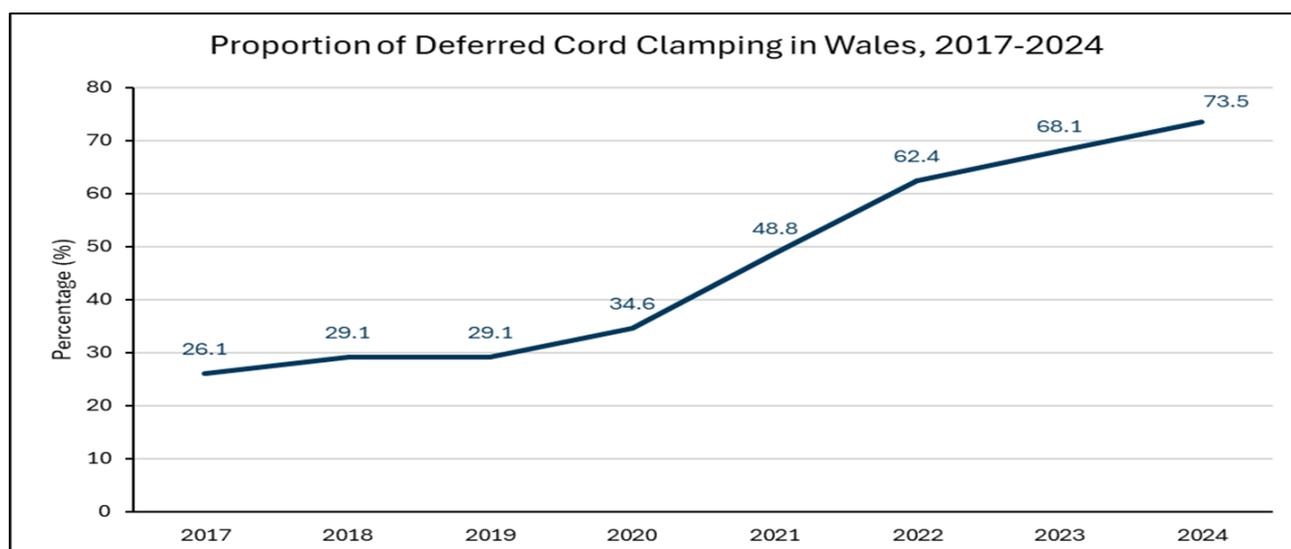
Source: NNAP Restricted Access Dashboard.

Note: Proportion of babies born at less than 34 weeks gestational age that had their cord clamped at or after one minute.
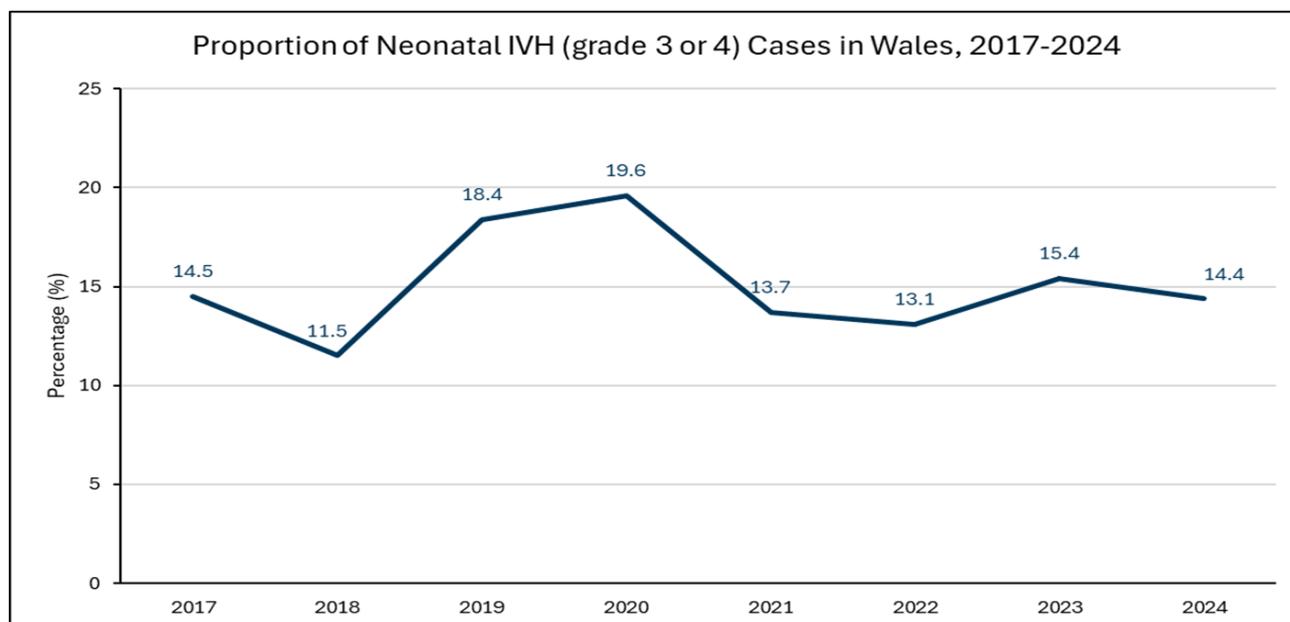
Figure 29: Proportion of neonatal bloodstream infections in Wales, 2017-2024.

Proportion of Neonatal Bloodstream Infections in Wales, 2017-2024

Source: NNAP Restricted Access Dashboard.

Note: Proportion of babies born at less than 32 weeks' with one or more episodes of bloodstream infection, characterised by one or more positive blood cultures taken after 72 hours of age.

Figure 30: Proportion of neonatal intraventricular haemorrhage (IVH) (grade 3 or 4) cases in Wales, 2017-2024.

Proportion of Neonatal IVH (grade 3 or 4) Cases in Wales, 2017-2024

Source: NNAP Restricted Access Dashboard.

Note: Proportion of babies born at less than 32 weeks' gestational age that experience intraventricular (IVH) grade 3 or 4.

Figure 31: Proportion of neonatal BPD or death cases in Wales, 2017-2024.

Proportion of Neonatal BPD or Death Cases in Wales, 2017-2024
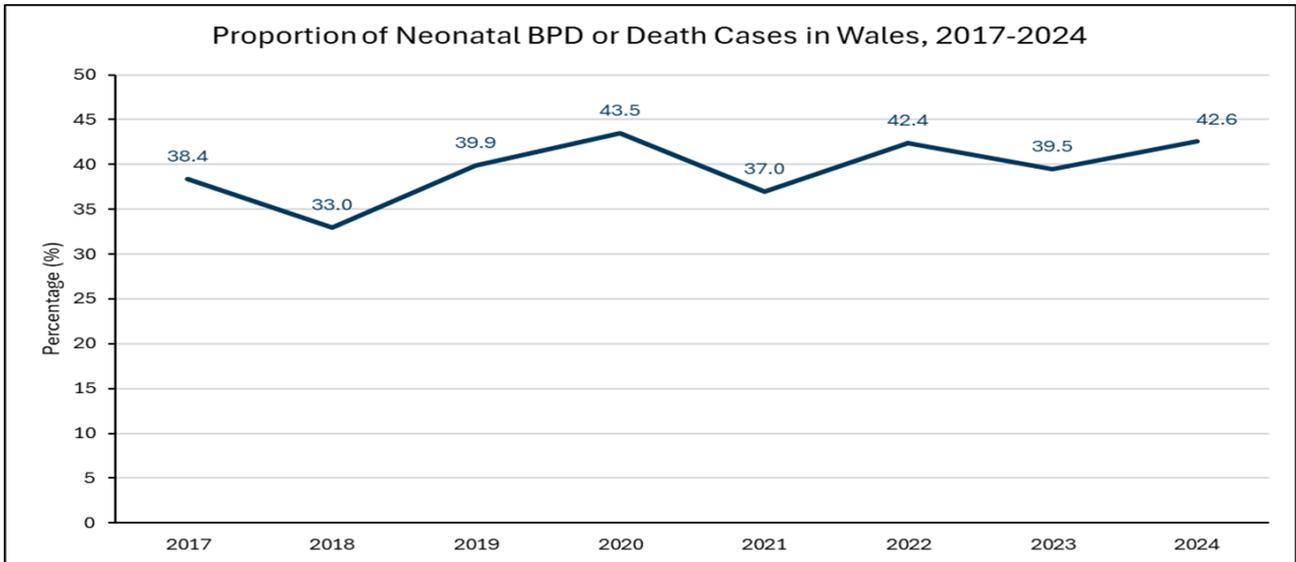
Source: NNAP Restricted Access Dashboard.

Note: Proportion of admitted babies born at less than 32 weeks' gestational age that develop bronchopulmonary dysplasia (BPD) or die.

Figure 32: Proportion of parent consultations that took place within 24 hours of admission, Wales, 2017-2024.

Proportion of Parent Consultations that Took Place Within 24 Hours of Admission, Wales, 2017-2024
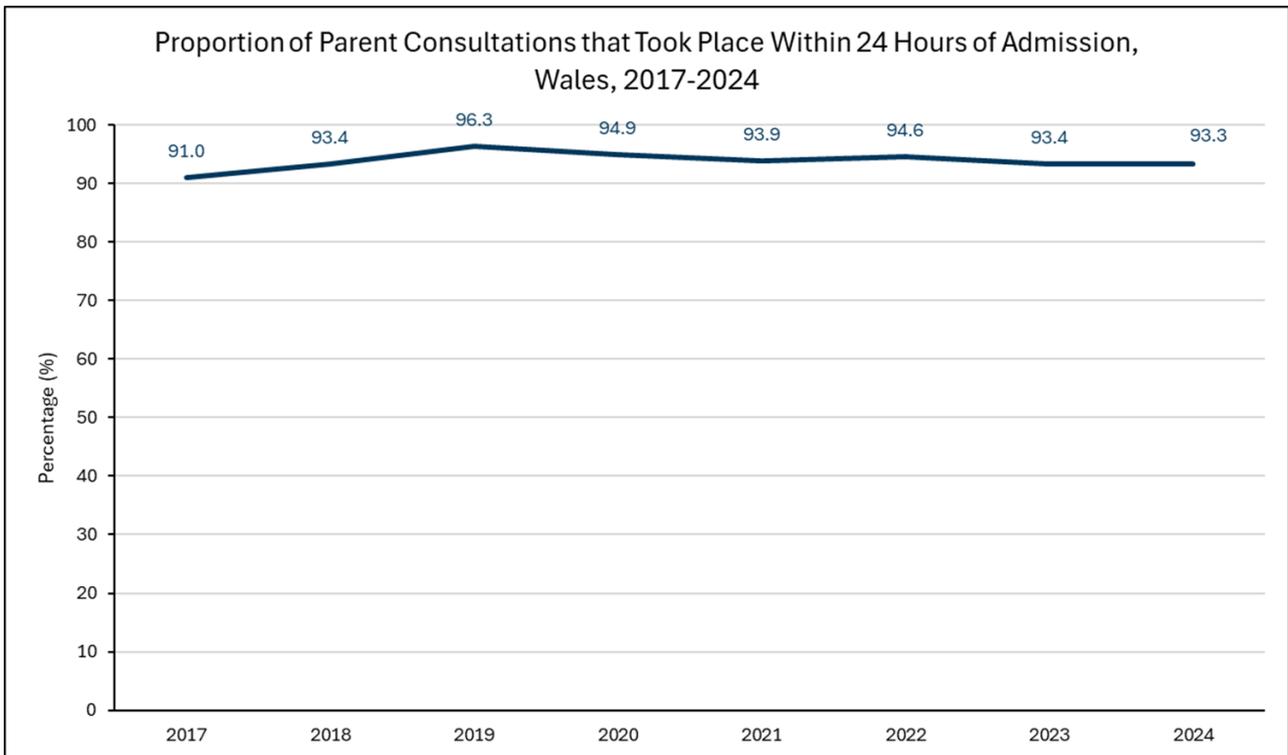
Source: NNAP Restricted Access Dashboard.

Appendix G: Quality Statement for Maternity and Neonatal Services – attributes of perinatal care

Priority 1: Joined up national perinatal leadership to ensure consistency in strategic planning, quality and safety across Wales

Safe	Leadership	Information	Learning, improvement and research
1. Consistent use of person-centred, evidence-based pathways of care, delivered by a skilled multiprofessional workforce, supported by robust clinical governance arrangements and escalation pathways from ward to board. 2. Risk held within the service is systematically assessed, communicated and escalated within the organisation as well as through national governance systems, with appropriate measures taken to proactively reduce the potential for harm.	21. Compassionate and inclusive leadership is demonstrated, enabling transformative change in a coordinated way from ward to board, supported by clear lines of communication and escalation, with a named executive board member responsible for perinatal services. 22. Robust succession planning is in place for existing and future leaders, with equity of access to developmental opportunities.	28. An intelligent suite of nationally agreed process, experience and outcome measures is systematically captured and regularly scrutinised by clinical, managerial and executive teams, with appropriate escalation and actions taken aligned to local and national assurance and improvement mechanisms.	31. The workforce is actively engaged in delivering evidence-based local and national quality improvement initiatives which are informed by feedback from women, parents and families, as well as insights from national bodies and audit programmes, with consistent approaches to evaluation and sharing learning.

Priority 2: A universal offer of quality care throughout the perinatal journey

Equitable	Person centered	Information	Learning, improvement and research
11. Women, parents and families are enabled to communicate in the language and method of choice to meet their individual needs, with the Welsh language actively offered. 12. Protected characteristics, social and cultural backgrounds and additional care needs are recognised as integral to providing accessible, equitable and person-centred perinatal services.	14. Appropriate and timely information is provided in multiple languages and formats, and women are supported to make informed decisions throughout their pregnancy, birth planning, birth and the postnatal period. A range of birth settings are available including hospital, birth centre and home birth	29. Integrated perinatal digital clinical systems are adopted to inform a single national dataset and enable delivery of safe, high-quality and consistent services where data is available to support shared decision-making, inform service delivery, drive improvements and contribute to safe and person-centred care.	30. Women, parents, families and staff are encouraged and supported to participate in local and national perinatal research to advance knowledge and improve care, experiences and outcomes.

Priority 3: Urgent attention to critical clinical safety issues

Safe	Effective	Information	Whole systems approach
1. Consistent use of person-centred, evidence-based pathways of care, delivered by a skilled multiprofessional workforce, supported by robust clinical governance arrangements and escalation pathways from ward to board. 2. Risk held within the service is systematically assessed, communicated and escalated within the organisation as well as through national governance systems, with appropriate measures taken to proactively reduce the potential for harm.	7. Standardised reporting and multiprofessional perinatal investigation for adverse events is undertaken, with effective local and national processes in place to share learning, implement changes and reduce the risk of future harm. Openness and transparency are demonstrated in line with the duty of candour, and women, parents and families are involved throughout the investigation process	28. An intelligent suite of nationally agreed process, experience and outcome measures is systematically captured and regularly scrutinised by clinical, managerial and executive teams, with appropriate escalation and actions taken aligned to local and national assurance and improvement mechanisms.	32. Collaborative working is embedded across professions, services, health boards and wider agencies involved in providing care and support, with a seamless transition between primary, secondary and tertiary care. This must include strong partnership working for regional services. 33. Integrated safeguarding systems and processes are in place with all partner organisations to ensure a holistic approach to keeping children and adults safe from violence, abuse and neglect.

Priority 4: Adequate staffing and estates to deliver safe and quality care

Workforce	Culture
23. The national strategic perinatal workforce plan is implemented, ensuring appropriate multiprofessional staffing across services. Workforce information is readily available and used to support optimal staffing and planning. 24. The workforce undertakes multiprofessional training and has access to service-specific programmes of continuing professional development to ensure skills are maintained and further developed, as well as aid workforce retention and career progression.	26. The health, wellbeing and safety of staff is prioritised at all levels of the organisation. Psychological is embedded and timely support is available to understood and meet the needs of the workforce. 27. A just, learning and improvement culture is fully embedded in line with service and organisational values and behaviours, and staff at all levels are supported and actively encouraged to raise any concerns in line with the speaking up safely framework.

Priority 5: Mental health support

Equitable	Person centered
12. Protected characteristics, social and cultural backgrounds and additional care needs are recognised as integral to providing accessible, equitable and person-centred perinatal services.	15. Healthcare professionals respect and support the autonomy of women as decision-makers regarding their own care, and ensure they are made aware of their rights around consent. 16. Unnecessary separation of mothers and babies should be avoided with transitional care provision consistently available. 17. Parents are supported and empowered to be primary care givers and viewed as equal partners in all aspects of their baby's care. A family integrated care model will be facilitated whilst babies are on the neonatal unit. 18. The all-Wales perinatal engagement framework is implemented to ensure the ideas, feedback and concerns of women, parents and families are heard and acted upon, with consistent use of person-reported experience measures, real-time engagement and co-production methods. This data is routinely triangulated with other insights, quality metrics and outcome measures.

Priority 6: Optimal neonatal care commissioning

Timely	Effective	Information	Learning, development and research	Whole systems approach
4. Systems and processes are in place for effective multiprofessional and multiagency communication across perinatal services to deliver care in the most appropriate place and time. 5. Timely, robust and evidence-based assessment is undertaken for all aspects of perinatal care in line with agreed protocols, overseen by skilled and experienced professionals to enable effective decision-making and clinical prioritisation.	6. Universal care pathways are autonomously provided by midwives to ensure a holistic approach to care, with additionality depending on the level of complexity. Women receive dedicated support from the same midwifery team throughout their pregnancy in line with the continuity of carer model. 7. Standardised reporting and multiprofessional perinatal investigation for adverse events is undertaken, with effective local and national processes in place to share learning, implement changes and reduce the risk of future harm. Openness and transparency are demonstrated in line with the duty of candour, and women, parents and families are involved throughout the investigation process.	29. Integrated perinatal digital clinical systems are adopted to inform a single national dataset and enable delivery of safe, high-quality and consistent services where data is available to support shared decision-making, inform service delivery, drive improvements and contribute to safe and person-centred care	30. Women, parents, families and staff are encouraged and supported to participate in local and national perinatal research to advance knowledge and improve care, experiences and outcomes.	32. Collaborative working is embedded across professions, services, health boards and wider agencies involved in providing care and support, with a seamless transition between primary, secondary and tertiary care. This must include strong partnership working for regional services. 33. Integrated safeguarding systems and processes are in place with all partner organisations to ensure a holistic approach to keeping children and adults safe from violence, abuse and neglect.

Priority 7: A reliable process for review and investigation, that involves families and leads to timely learning

Effective	Culture	Information	Learning, development and research	Whole systems approach
7. Standardised reporting and multiprofessional perinatal investigation for adverse events is undertaken, with effective local and national processes in place to share learning, implement changes and reduce the risk of future harm. Openness and transparency are demonstrated in line with the duty of candour, and women, parents and families are involved throughout the investigation process.	27. A just, learning and improvement culture is fully embedded in line with service and organisational values and behaviours, and staff at all levels are supported and actively encouraged to raise any concerns in line with the speaking up safely framework.	28. An intelligent suite of nationally agreed process, experience and outcome measures is systematically captured and regularly scrutinised by clinical, managerial and executive teams, with appropriate escalation and actions taken aligned to local and national assurance and improvement mechanisms.	31. The workforce is actively engaged in delivering evidence-based local and national quality improvement initiatives which are informed by feedback from women, parents and families, as well as insights from national bodies and audit programmes, with consistent approaches to evaluation and sharing learning.	32. Collaborative working is embedded across professions, services, health boards and wider agencies involved in providing care and support, with a seamless transition between primary, secondary and tertiary care. This must include strong partnership working for regional services. 33. Integrated safeguarding systems and processes are in place with all partner organisations to ensure a holistic approach to keeping children and adults safe from violence, abuse and neglect.

Priority 8: Developing an in-depth understanding of need, experience and outcomes through engagement and evaluation

Person centred	Information	Learning, development and research	Whole systems approach
19. Women are supported with their chosen method of feeding and receive the information and guidance required. Breastfeeding is promoted to help to reduce broader health inequalities and contribute to it being viewed as a culturally accepted norm across Wales. 20. The national bereavement care pathways are implemented to ensure equitable access to bereavement care and support for women, parents and families who have experienced death of a baby during pregnancy, birth or in the neonatal period, regardless of their geographical area.	28. An intelligent suite of nationally agreed process, experience and outcome measures is systematically captured and regularly scrutinised by clinical, managerial and executive teams, with appropriate escalation and actions taken aligned to local and national assurance and improvement mechanisms.	31. The workforce is actively engaged in delivering evidence-based local and national quality improvement initiatives which are informed by feedback from women, parents and families, as well as insights from national bodies and audit programmes, with consistent approaches to evaluation and sharing learning.	32. Collaborative working is embedded across professions, services, health boards and wider agencies involved in providing care and support, with a seamless transition between primary, secondary and tertiary care. This must include strong partnership working for regional services. 33. Integrated safeguarding systems and processes are in place with all partner organisations to ensure a holistic approach to keeping children and adults safe from violence, abuse and neglect.

References for Appendices

- Figure 2: Health Education and Improvement Wales. Midwifery headcounts and FTE in Wales, 2015-2025. Midwifery headcounts and FTE in Wales, 2015-2025. Source: Health Education and Improvement Wales (HEIW). **Hafan - AaGIC**

- Figure 3: Midwifery FTE in Wales, by age band, March 2015 and March 2025. Source: Health Education and Improvement Wales (HEIW).

- Figure 4: Number of midwives commissioned in Wales, 2016-2025. Source: Health Education and Improvement Wales (HEIW). **Hafan - AaGIC**

- Figure 5: Midwives monthly sickness rates, Wales, January 2018- July 2025. Source: Health Education and Improvement Wales (HEIW). **Hafan - AaGIC**

- Figure 6: Neonatal nursing headcounts and FTE in Wales, March 2015- March 2025. Source: Health Education and Improvement of Wales (HEIW). **Hafan - AaGIC**

- Figure 7: Neonatal nursing FTE in Wales, by age band, March 2015 and March 2025. Source: Health Education and Improvement Wales (HEIW).

- Figure 8: Neonatal nurses monthly sickness rates, Wales, January 2018- July 2025. Source: Health Education and Improvement Wales (HEIW). **Hafan - AaGIC**

- Table 3: PROMPT compliance by health board, 01/09/24-31/08/25. Source: Welsh Risk Pool, NHS Wales Shared Services Partnership (NWSSP).

- Table 4: Intrapartum Fetal Surveillance (IFS) by health board, 01/09/24-31/08/25. Source: Welsh Risk Pool, NHS Wales Shared Services Partnership (NWSSP).

- Figure 9: Number of pregnancies by parity, Wales, 2016-2024. Source: Maternity Indicators Dataset (MIDS) - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

- Figure 10: Proportion of births in Wales, by mode of onset of labour, 2016-2023. Source: **Maternity Indicators Dataset (MIDS)**.

- Figure 11: Proportion of births in Wales, by mode of birth, 2016-2023. Source: **Maternity Indicators Dataset (MIDS)**.

- Figure 12: Proportion of births in Wales by mode of birth and deprivation quintile, 2024. Source: Maternity Indicators Dataset (MIDS) - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

- Figure 13: Number of pregnancies by parity and mode of birth, Wales, 2024. Source: Maternity Indicators Dataset (MIDS) - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

- Figure 14: Caesarean surgical site infection rate in Wales, 2023-2024. Source: Healthcare Associated Infection, Antimicrobial Resistance & Prescribing Programme (HARP), Public Health Wales (PHW). **Antibiotics and Infections - Public Health Wales**.

- Figure 15: Proportion of women by mode of birth with third- or fourth-degree perineal trauma, Wales, 2021-2024. Source: Maternity Indicators Dataset (MIDS) - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

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- Figure 20: Proportion of mothers who were breastfeeding in Wales, by age of mother, 2024. Source: **National Community Child Health Database (NCCHD).**

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- Figure 25: Overall perinatal status, South Wales Network cots, 25/09/2025 to 30/10/2025. Source: South Wales Network cot locator - data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

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- Figure 28: Proportion of deferred cord clamping in Wales, 2017-2024. Source: **NNAP Restricted Access Dashboard.**

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- Figure 30: Proportion of neonatal intraventricular haemorrhage (IVH) (grade 3 or 4) cases in Wales, 2017-2024. Source: **NNAP Restricted Access Dashboard.**

- Figure 31: Proportion of neonatal BPD or death cases in Wales, 2017-2024. Source: **NNAP Restricted Access Dashboard.**

- Figure 32: Proportion of parent consultations that took place within 24 hours of admission, Wales, 2017-2024. Source: **NNAP Restricted Access Dashboard.**