The path to safer beginnings in Wales

A national assurance assessment of Maternity and Neonatal care and services

February 2026

Foreword from the Chair of the panel

Pregnancy, birth and early care are foundational for each person's life course. Care provided during that crucial period is not only vital for a healthy physical and psychological start for babies and their mothers, but also for the whole family's relationships and wellbeing.

It is with that long view in mind that my expert panel and I began our work in September 2025 to complete an assurance assessment over a 4-month period of the quality and safety of maternity and neonatal services in Wales.

We set about this task with the commitment that when newly pregnant or considering having a baby, women and their partners need to be reassured about some fundamentals. They need to be confident that will they be treated with care, dignity and respect and that they will receive the individualised care they need and want. They should expect be listened to and meaningfully involved in decisions about their care. They should also feel trust and confidence that they and their baby will receive high-quality, safe care to prevent problems and to maximise their opportunities for a healthy pregnancy, birth and start as a new family.

Many newly pregnant women will face complex physical and mental health needs, social challenges and racism and statistics show that those facing these barriers will need additional support. The best health care systems will not just treat everyone equally but take action to reduce those inequalities.

To achieve these goals, healthcare systems must also ensure that staff at all levels are enabled to do the job they are committed to and have been educated and trained to do. They need time, support, equipment and a safe environment to do this.

This assurance assessment was requested by the Cabinet Secretary for Health and Social Care to take account of the findings of the recent reviews of maternity and neonatal services across the UK, including in Swansea Bay. He stated that he wished a 'real time' assessment of safety, but also that the assessment had been tasked with identifying examples of good practice as well as risks and concerns.

Our task has therefore been different from a retrospective review or inquiry into failings of a particular service. We have shaped our approach to enable us to identify both strengths within the current system as well as concerns. To do this, we have adopted a whole system, multi-method approach. We have carefully listened to hundreds of women, parents, families, community advocates and staff from all over Wales. We have visited nearly all maternity and neonatal units in Wales and observed practice as it happens. I am proud of what we have achieved to gain a rounded picture in a very short period.

What we have found

The view of the expert and independent panel of which I am Chair, is that there are many strengths in Welsh maternity and neonatal services, but there are some important vulnerabilities in some of the key conditions required for safe and reliable care.

Strengths

- These include much positive feedback from expectant women and their partners, and new mothers and fathers about many aspects of the quality of their care in maternity and neonatal services. Where they have not received the care they need, many are keen to help services improve.
- Staff who engaged with our assessment demonstrated a strong commitment to providing high quality and safe care throughout the maternity and neonatal pathway and we observed much positive practice during our site visits. This commitment was evident despite many challenges in the current system.
- Freestanding midwife-led units enable many women to receive antenatal and postnatal care and give birth in high-quality environments, particularly supporting those in rural areas to avoid long journeys to hospital.
- At a national and local level, there has been a renewed focus and commitment to maternity and neonatal services in the last few years, and this has led to positive changes in some measurable outcomes.

Despite these clear strengths, we are concerned about some key vulnerabilities and weaknesses.

- Many families report poor experiences, with concerns about postnatal support, the involvement of fathers and unmet mental health needs.
- Our assessment is that national organisations tasked with delivering, commissioning, monitoring, holding to account and driving improvements in maternity and neonatal services are too often working in parallel, rather than maximising the potential of their collective knowledge and remits. The potential for real-time monitoring of data and spotting unsafe trends, understanding inconsistencies and inequalities and setting national and local priorities is not yet realised.

- Current staffing levels and configurations do not meet the requirements of current population needs, nor the rapid increase in caesarean births and induction of labour. This means that safety and well-being is compromised throughout the maternity journey. Staff morale has been hit hard by these issues, and by what is experienced as a relentless negativity about maternity services in the public domain.
- There are inconsistencies in the organisation and staffing of triage and induction of labour processes and shortages of obstetric theatre provision. Postnatal care, especially, is inadequately staffed and supported.
- Analysis and necessary reconfiguration of neonatal provision in south Wales has been unduly delayed.
- Wales lags behind Scotland and England in its provision of mental health care in maternity and neonatal units.
- The process of responding to incidents, including death and serious injury, is inconsistent, overly procedural and does not reliably involve families. It often serves to further traumatise families who have experienced harm and limits the capacity to learn and improve.
- And finally, but importantly, Wales along with the rest of the United Kingdom has seen an unprecedented rise in medical interventions, particularly caesarean rates, without evaluating the consequences for women, babies, families, and for health service resources.

Our recommendations address these vulnerabilities.

My panel members, who have extensive experience of maternity and neonatal services in all four nations of the United Kingdom have confirmed that the challenges facing Wales are replicated across the United Kingdom. While keeping a close eye on Wales's population profile, culture and geography, we have indicated in our recommendations where Wales may wish to either draw on work already underway in other UK nations or where it may be prudent for cross-national collaboration to find the most effective solutions to shared challenges.

Members of the excellent Stakeholder panel and Consultative groups have made passionate pleas that this report must create change. They noted that there have been many reports, with good recommendations, but women, families and staff haven't experienced those changes in practice. Our recommendations will require action, funding and accountability. I expect Welsh Government to lay out clear mechanisms to address the issues highlighted in this report, including transparency on how this process will be measured, monitored and reported. The challenges are large, but they are solvable, if they include those who rely on or work in Wales's maternity and neonatal services every step of the way.

Professor Sally Holland

Independent Chair

9 February 2025

Acknowledgements and thanks

I would like to thank the more than 600 family, community and staff members who gave generously of their time to share their experiences of maternity and neonatal services with us. Health Boards and national governments answered all of our queries with willingness and openness and maternity and neonatal units throughout Wales allowed us to spend time with them, understanding their daily achievements and challenges. Members of our Families and Communities Consultative Group, and our Stakeholder Panel, provided vital sense-checking and appropriate challenge. The NHS Wales Performance and Improvement team, worked exceptionally hard to support our data collection and analysis, often working long days alongside panel members. Finally, I'd like to thank the expert members of the panel, who have shared their extensive knowledge and experience and a great deal of their time, and from whom I've learned so much.

Membership of the Independent Oversight Panel; Stakeholder Group; Women, Parent and Family Engagement Consultative Group and organisations that participated in the listening sessions are included in Appendix A

The terms 'woman' / 'women' have been used throughout this report as this is the way the majority of those who are pregnant and having a baby will identify. Others giving birth includes girls, and also includes those whose gender identity does not correspond with their birth sex or who may have a non-binary identity. All professionals should be respectful and responsive to individual needs and individuals should be asked how they wish to be addressed throughout their care.

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Section 1: Introduction

Origins of Commission

The all-Wales Maternity and Neonatal Assurance Assessment was commissioned by the Cabinet Secretary for Health and Social Care in response to ongoing concerns and variability in the safety, quality, and experience of maternity and neonatal care across Wales. This assessment builds on the lessons learned from previous high-profile reviews conducted both within Wales and across the UK. In contrast, the Cabinet Secretary's commission for Wales was not a review, it was a forward-facing assurance assessment. This distinction is vital: an assurance assessment is not about assigning blame, but about building confidence in the quality, safety, equity, and experience of care now and in the future.

Recognising the importance of maintaining public confidence and ensuring continuous improvement, NHS Wales Performance and Improvement (NHSP&I) was tasked with leading this comprehensive assurance assessment. The assessment is independently chaired and supported by a multidisciplinary Oversight Panel, ensuring impartiality, credibility, and a strong foundation for evidence-based recommendations. It forms a critical component of the Welsh Government's broader programme to strengthen maternity and neonatal services and aligns with the Maternity and Neonatal Safety Support Programme[1] and the national Datganiad Ansawdd ar Gyfer Gwasanaethau Mamolaeth a Newyddenedigol; Quality Statement for Maternity and Neonatal Services[2].

Why It Matters

This assurance assessment is a pivotal step in safeguarding the health and wellbeing of women, parents, babies, and families across Wales. Despite progress in clinical practice and service delivery, persistent variations in care quality and outcomes continue to pose risks. The assessment matters because:

- It places lived experience at the centre, ensuring that the voices of women and families directly inform service evaluation and improvement.
- It provides a current, evidence-based snapshot of service performance, culture, and governance—highlighting both strengths and areas requiring urgent attention.
- It promotes equity and consistency by identifying unwarranted variation and ensuring that all families receive safe, high-quality, and compassionate care.
- It enables timely escalation of safety concerns, ensuring that risks are addressed before they result in harm.
- It supports a culture of openness, learning, and continuous improvement, helping services to evolve in response to emerging evidence and community needs.

- It strengthens national oversight and accountability, providing the Cabinet Secretary and system leaders with the insights needed to drive strategic improvements.

Ultimately, this assessment is about building a safer, more responsive, and inclusive perinatal care system—one that earns and sustains the trust of the communities it serves.

Background

Maternity and neonatal services across Wales are committed to delivering safe, high-quality, and compassionate care for women, parents, babies, and families. However, despite significant progress in clinical practice and service delivery, persistent variation in safety, quality, and experience remains a concern. A series of high-profile reviews across the UK and within Wales have exposed systemic failures and highlighted the need for strengthened oversight, learning, and improvement.

In response, the Welsh Government has commissioned a forward-looking national assurance assessment of perinatal services. Unlike retrospective reviews that focus on past incidents, this assessment is designed to evaluate the current state of maternity and neonatal care across Wales. It aims to provide assurance that services are safe, effective, and responsive, while also identifying areas of excellence and opportunities for improvement.

The assessment was independently chaired and supported by an independent multidisciplinary Oversight Panel. Its findings will inform the Cabinet Secretary for Health and Social Care and contribute to the ongoing development of the Maternity and Neonatal Safety Support Programme[1]. Central to this work is a commitment to placing the voices and experiences of women, parents, and families at the heart of the evaluation process.

Welsh context

The assurance assessment is situated within a uniquely Welsh policy and service delivery landscape. NHS Wales operates under a devolved health system, with a strong emphasis on integrated care, equity, and continuous improvement. The Welsh Government's Quality Statement for Maternity and Neonatal Services[2] and supporting Quality Standards provide a clear framework for what high-quality, person-centred care should look like across the perinatal pathway.

This assessment aligns with national priorities to strengthen safety, reduce unwarranted variation, and promote a culture of openness and learning. It also supports the re-prioritisation of the Maternity and Neonatal Safety Support Programme[1], ensuring that improvement efforts are coherent, evidence-based, and responsive to emerging insights.

Importantly, the assessment recognises the diversity of maternity and neonatal service configurations across Wales, reflecting the distinct needs of rural, urban, and cross-border populations. The assessment considered how services are structured to meet local demographic and geographic requirements and considered relevant interfaces where this may influence the safety, experience and quality of maternity and neonatal care. Although health visiting and GP services were largely out of scope of this assessment, their contribution to perinatal care is important and acknowledged.

A glossary of terms relevant to this report is included in Appendix B.

Section 2: Methods of the assurance assessment

Approach and workstreams

The assurance assessment was led by an Independent Chair, supported by a panel of seven experts (Appendix A) and a multidisciplinary project team from NHS Wales Performance and Improvement (NHS P&I) and Welsh Government, with input from a stakeholder panel with an interest in improving the quality of maternity and neonatal services.

Methods were designed to address the aims and objectives established by the Welsh Government Terms of Reference[3].

The approach aimed to:

- Draw extensively on engagement with women, parents and families, community and advocacy groups, and with multidisciplinary staff
- Consider inequalities and ensure engagement with those whose voices are seldom heard
- Examine the whole system that provides and influences maternity and neonatal care, across the whole maternity journey from pregnancy to postnatal care, in hospital and community
- Consider all aspects of safety and quality – physical, psychological, social and cultural
- Learn from positive aspects of care and services using a strengths-based approach
- Consider the short and long-term impact of care and services during pregnancy, birth, postnatally and the early days and weeks of life
- Draw on data and evidence to inform analysis and recommendations

Six inter-related workstreams were established:

- Assessment of national data and evidence related to maternity and neonatal services (Terms of Reference Aims 2 and 5, Section 3)
- Analysis of previous reports and reviews relevant to maternity and neonatal services in Wales (Aims 3 and 5, Section 3)
- Women, partners/parents and family engagement: engagement with women, partners/parents and families with a range of experiences of maternity and neonatal care across all regions in Wales (Aim 3, Section 4)

- Understanding the experiences of staff in perinatal services: engagement with multidisciplinary staff working in maternity and neonatal services across all regions in Wales (Aim 3, Section 5)
- Healthcare organisational leadership, culture and governance: assessment of organisational leadership, reporting and governance across organisations in Wales with responsibility for maternity and neonatal services (Aims 1, 2, 4, 5, Section 6)
- Site visits: conducting site visits in all Health Boards to provide real-time insights into the maternity and neonatal environment from the perspectives of women, partners/parents, families, and staff (Aims 2, 3, 4, Section 7)

There was overlap and some duplication of topics across the workstreams. This was deliberate and seen as a strength, enabling comparison, cross-checking, and triangulation of findings. Input from the Stakeholder Group and the Women, Parent and Family Engagement Consultative Group (Appendix A) informed the work throughout.

Governance, ethics, and oversight of the workstreams; safeguarding women, partners/parents, families, and staff

All workstreams adhered to a Data Protection Impact Assessment and Standard Operating Procedures put in place to ensure safeguarding of women, partners/parents, families and staff, and confidentiality in the collection, storage, and analysis of data. Steps taken to safeguard women, partners/parents, families and staff included:

- All records and data relating to the assurance assessment were processed according to the information sharing agreements and data protection requirements. Any handwritten notes were kept securely and submitted for secure destruction at the end of the workstream's activities
- Communications out to the Health Boards and the public clarified that all information shared would remain anonymous unless individuals gave consent to be identified
- Engagement methods were designed to avoid or minimise harm to women, partners/parents, families and staff
- A variety of engagement methods was offered to meet diverse needs, including group and one-to-one meetings in person and virtual, and written submissions
- Specialist professional counselling services were commissioned to provide support to any participants who wished
- Any concerns about immediate safety were reported/escalated using existing procedures and a risk register was maintained throughout the work
- Regular meetings of panel members and NHS Wales Performance and Improvement colleagues were held to assess progress, and any problems were rapidly addressed.

Methods of the workstreams[4]

Assessment of national data and evidence related to maternity and neonatal services

Welsh national data on population, services and staffing, processes, outcomes and experiences were collated from a range of sources. Some were publicly available; some were extracted from a range of data sources specifically for this assessment by analysts from NHS Wales Performance and Improvement; along with relevant benchmarking data from other UK countries. Data submitted by Health Boards was also scrutinised, but details have not been included because boards presented data in different ways.

Structured reviews of research evidence on safe, quality care and services, conducted as part of the Independent Report from Northern Ireland, were used to inform aspects of this work as was another relevant research.

Analysis of previous reports and reviews relevant to maternity and neonatal services in Wales

Multiple reports and reviews of maternity and neonatal services in Wales and across the UK have been conducted over the past decade. Together they have produced more than 500 individual recommendations across multiple documents. A single, structured, Wales-specific thematic analysis was conducted to examine the key messages from these reports and inform the work of this assurance assessment.

Twenty-six reports were identified, including four major UK reviews, five reports of national oversight, inspection and review from Wales, two independent Health Board reviews, one statutory and regulatory source, four audit, surveillance and national programmes, two family voice and public engagement reports, four policy, professional and strategic frameworks, and four reports on professional and thematic evidence.

A total of 523 individual recommendations relevant to maternity and neonatal care in Wales were analysed to identify recurring themes. Recommendations were extracted into a spreadsheet. Any that were duplicated, irrelevant to the Welsh context, or non-actionable were removed. The remaining 463 recommendations were analysed in a structured process drawing on five complementary frameworks that together describe:

- what high-quality care should feel like (Quality Maternal and Newborn Care (QMNC) Framework[5])
- what foundational conditions must exist in a maternity and newborn health system (System Conditions[6])
- what type of change the system is being asked to make (Transformative Change Categories[7])
- how quality is operationally delivered (Quality Management System domains[8])
- how findings align with statutory expectations in Wales (Duty of Quality[9]).

This structured approach enabled identification of what the recommendations said, why certain issues persist, where the strengths lie, and how structural factors shape everyday experience for women, babies, partners and parents, families and staff. It also enabled identification of gaps in the recommendations that had the potential to influence safety and quality.

Women, partners/parents and family engagement: engagement with women, partners/parents and families with a range of experiences of maternity and neonatal care across all regions in Wales

Engagement with women, partners/parents and families was conducted between November 2025 and January 2026. The methods used were designed to hear from women, partners/parents, and families with a diversity of backgrounds and experiences, either individually or in groups. Active steps were taken to ensure engagement with global majority communities and other communities whose voices are seldom heard. The steps taken to safeguard and support participants are detailed in Section 2. The work was supported by all Health Boards and by a range of community groups.

The initial plan was to hold group listening sessions across all the Health Boards. However, invitations sent through a range of social media and Health Boards resulted in very low attendance at these pre-arranged groups, and multiple requests for one-to-one sessions were received instead. The plan was revised in line with advice from women themselves that using local support and community groups to meet with women, partners, parents and families in a setting and environment that was convenient to them would be most effective.

To ensure as many communities as possible were reached, links were made with Health Board leads and key organisations such as the third sector, local authorities, Flying Start[10] and community groups. These organisations were very supportive and enabled engagement with key groups across their localities ensuring that all those who wished to engage in the process were supported to do so.

Women, parents, partners and families who had tragically lost babies, or whose baby had suffered long-term brain damage or other conditions were given the opportunity to speak with the lead panel member or a colleague privately, either in person or in a video meeting. In most cases, the family chose the option of a video meeting. In every case the conversation triggered the trauma previously endured. This was acknowledged in these meetings and professional specialist counselling support was offered to all.

This work resulted in:

- Eighteen community group sessions were conducted across all Health Board localities, with 175 participants including women, partners, parents, and other family members
- Thirty-eight women shared their stories and experience in writing via a QR code on the promotion leaflet.
- One-to-one listening sessions were held with 28 individuals

Those who engaged included women, partners, parents and families:

- who had their first or subsequent baby
- those who had suffered a miscarriage or whose baby had died or suffered harm
- from Global Majority communities
- who were living in areas of high deprivation including those in Flying Start[10] postcode areas.

The information captured through all routes of engagement was scribed and submitted to an app designed specifically for this purpose (the Perinatal Survey App (PSA)). A note taker attended each session, collecting feedback and initially uploading this information to the app. This enabled the data to be combined with that received from other data sources such as the National Patient Experience Survey[11], maternity and neonatal data and other key measures for inclusive analysis across workstream activities.

The information was analysed and organised in three categories: looking back, the present, and looking ahead.

Understanding the experiences of staff in perinatal services: engagement with multidisciplinary staff working in maternity and neonatal services across all regions in Wales

A letter was sent to each Health Board from the lead panel member for this workstream to explain the purpose of the independent assurance assessment and more specifically the staff experience workstream. The panel lead also attended several Health Board meetings to answer any questions regarding the process and to give details of the ways staff could contribute. Engagement was conducted in three ways:

Listening sessions

A series of Health Board in-person and/or virtual sessions were held across Wales which brought together staff with a shared characteristic, e.g. those who worked for the same Health Board or who were in similar roles across Wales. In total 15 visits to 11 hospital sites in six Health Boards were conducted in person, with one online. One Health Board had recently completed considerable staff consultation as part of their own Independent Review process and the decision was made to not meet with those colleagues to avoid duplication. More than 250 multidisciplinary staff attended these sessions. Each session aimed to provide a safe and open space for colleagues to share their experiences, challenges, and suggestions through facilitated discussions and participatory activities to encourage dialogue and to capture a broad range of perspectives. Sessions were led by the panel member responsible for the workstream. A common model of facilitation was used across all sessions, with some adaptation of questions asked and time spent on topics contingent on group dynamics. Staff attending were invited to provide their background information confidentially and securely during the workshops through an anonymous survey. This enabled capture of demographic information and described the breadth of staff voices heard. Submission of this information was not mandated and only 34 individuals provided this information.

Twelve face-to-face staff listening events were also conducted. Four group meetings were held with representatives of UNISON, the Royal College of Nursing (RCN) and the Royal College of Midwives (RCM), two virtual and two face-to-face, to explore the issues they were regularly encountering in their work to support staff. In addition, five virtual listening sessions with targeted groups were held to gain a variety of perspectives. These included online group sessions for Directors and Heads of Midwifery, Consultant Midwives, Neonatal Nurses, specialist Perinatal Mental Health Midwives, Resident Doctors and Allied Health Professionals. Clinical Directors were unable to arrange a session within the timeframe, but several participated in senior site visit meetings.

Staff interviews

Individual, and where requested anonymous, interviews were offered as a one-to-one opportunity either in-person, via MS Teams or telephone. This enabled staff to share their experiences privately with the lead panel member. A web page was established with a link to a booking form, which enabled NHS staff to request a 30-minute slot with the lead panel member. Booking information was stored on an administrator's OneDrive and emailed automatically to the secure email address for this workstream. Designated staff from NHS P&I monitored this email box and booked timeslots directly in the dedicated online diary. 107 one-to-one interviews were conducted.

Online form or email submission

For those individuals unable or hesitant to attend listening sessions or staff interviews, provision was made for anonymous feedback through a simple online form or email to a dedicated inbox. Fifty submissions were received using this option. These messages were reviewed by the lead panel member. Direct quotes were reviewed against the identified themes and included in the description of experiences.

Analysis of findings

Findings from all sessions were recorded on a spreadsheet or on the PSA app specifically designed to support the engagement, and in writing as contemporaneous notes including direct quotes. This mixed approach was developed to address the varying numbers of staff at events and to ensure there was consistency.

Analysis of the findings was led by the lead panel member. Drawing on an action learning approach, themes were generated interactively. Early listening sessions were used to identify emerging themes, and later meetings were used to further develop and validate them.

Healthcare organisational leadership, culture and governance: assessment of organisational leadership, reporting and governance across organisations in Wales with responsibility for maternity and neonatal services

Gaining insight into organisational leadership, culture, and governance at Health Board and national levels was conducted in two phases: a) with all Health Boards, and b) with national organisations. In addition, information on these aspects were drawn from and across other workstreams as appropriate.

Self-assessment by organisations

Organisational maturity across all NHS Wales providers delivering maternity and neonatal services was assessed using an approach that combined structured self-assessment, formal validation processes, evidence review and semi-structured discussions with executive teams as well as senior clinical and operational leaders. The aim was to generate a comprehensive and triangulated understanding of organisational culture, governance, leadership, and service quality.

The panel lead wrote to all Health Boards to outline the process and routes to raise any queries, and they attended a meeting with a representative from all Health Boards present to answer any queries and ensure they were supported in understanding the process and workstream approach.

Development and deployment of the self-assessment tool

Health Boards were informed at an early stage that a structured self-assessment would form part of the assurance process. The tool was developed by NHS P&I, drawing on national quality frameworks, established assurance methodologies, and findings from previous maternity and neonatal reviews. Following review by the Independent Panel, the tool was refined to incorporate additional free-text questions and a requirement for evidence to substantiate all maturity scores.

The tool assessed organisational maturity across eight domains aligned to the Welsh Government commission. A four-level maturity rubric (Appendix C) was used to describe progression from reactive and inconsistent practice to fully embedded, system-wide learning and improvement. Each Health Board was required to complete a separate assessment for each maternity and neonatal unit, supported by a bespoke SharePoint-based digital platform with automated submission and validation functions. There was variation in the level at which each Health Board scored themselves with some providing overall score for the Health Board and some at each unit level. For the purposes of the charts in Appendix D, where there were multiple scores at unit level these were aggregated to have one average score per Health Board.

Validation and data analysis

Each section of the tool required internal validation by a senior Health Board colleague prior to final submission. The system automatically recorded the identity of individuals submitting and validating entries to ensure traceability and to support follow-up where clarification was required. Submitted data underwent quantitative and qualitative analysis by NHS P&I, supported by digital tools for thematic analysis. Data visualisations were produced at unit, Health Board, and national levels and shared with the Independent Panel to inform collective interpretation and decision-making.

Evidence submission and review

Health Boards were required to upload evidence to justify and substantiate their maturity assessments. Evidence was categorised as core, supplementary, or other locally relevant material. A total of 4,554 documents were submitted, of which 2,287 were unique. The range in number of documents submitted by each Health Board was extensive ranging from 281 by one Health Board to 1335 in another, with the corresponding number of unique documents being 200 and 848, which highlights the level of duplication of documents within the submissions.

While it was not feasible to review all evidence in detail, the panel lead undertook targeted review ahead of each semi-structured discussion and used the evidence to triangulate statements with intelligence from other workstreams, test assumptions, and explore areas requiring further scrutiny. At this stage, there was triangulation with and scrutiny of how the evidence submitted tied into the national oversight frameworks, partner organisations and national governance structures. This provided a basis to test assumptions and the associated maturity scores, as well as explore areas requiring further scrutiny during the semi-structured meetings. Any variation in approach to the Health Boards submissions was considered during this evidence review stage.

Because of the intensive nature of this work and the need to triangulate with findings from other workstreams, these interviews were planned to take place at a later stage of the assessment.

Semi-structured discussions with Health Boards

The final stage of the self-assessment involved semi-structured discussions with each Health Board to explore their submissions, organisational context, and perinatal service arrangements. Discussions explored aspects of the eight domains of the organisational maturity framework and were designed to facilitate open dialogue, clarify areas of uncertainty, and help to triangulate findings across workstreams. In addition to the eight domains, some overarching strategic questions relating to the national overnight frameworks and national governance structures were also explored.

Sessions were held via MS Teams and involved the panel lead, a second panel member, and a note taker from NHS P&I. Two or three discussions were held per organisation, engaging senior service managers, executive Board members, and, where appropriate, non-executive board members.

Understanding national-level governance and commissioning

It became clear during this and other workstreams that information was needed on governance and commissioning of maternity and neonatal services at national level. A questionnaire was developed (Appendix E), informed by one used as part of the Independent Report in Northern Ireland[6]. Questions addressed funding and commissioning of services, governance and assurance of quality and safety, inter-relationships and communication between national bodies, and the links between education and service commissioning.

This was sent to: Welsh Government, Health Education and Improvement Wales (HEIW), Health Inspectorate Wales (HIW), NHS Wales Joint Commissioning Committee (JCC), Welsh Risk Pool (WRP), and NHS Wales Performance and Improvement (NHS P&I). Prompt responses were received from all of these.

Further information was gained from discussions with Health Board executive and clinical directorate teams. The Chair held meetings with the Welsh Ambulance Service University Trust (WAST), the Nursing and Midwifery Council (NMC), Health Inspectorate Wales, NHS Wales Joint Commissiong Committee, the Lead Midwives for Education for university midwifery degree programmes, Welsh Risk Pool and Health Education and Improvement Wales. NHS Wales Performance and Improvement and Welsh Government attended all panel meetings as observers and further questions were therefore asked of these bodies throughout the assurance assessment.

Analysis was conducted by panel members who identified key themes, with responses triangulated across other workstreams.

Site visits: conducting site visits in all Health Boards to provide real-time insights into the maternity and neonatal environment from the perspectives of women, families, and staff

Site visits were conducted in each of the seven Health Boards in Wales (Aneurin Bevan University Health Board, Betsi Cadwaladr University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board, Hywel Dda University Health Board, Powys Teaching Health Board and Swansea Bay University Health Board), to gain real-time insight into the perspectives of women, partners/parents, families and staff into the culture and practices in maternity and neonatal units. Visits aimed to focus on inpatient areas including antenatal clinics, labour wards, postnatal wards, and neonatal units. Eighteen site visits were undertaken in a three-week period in November-December 2025. They were conducted by teams comprising NHS P&I colleagues representing maternity and neonatal care and where possible an independent panel member and a patient and people partner. The visit schedule was developed with Health Boards and overseen by the lead panel member for the workstream.

The NHS England 15 steps challenge[12] methodology was used, adapted to allow deeper exploration through structured clinical prompts and key lines of enquiry. Assessment criteria were agreed and established, and a standardised observation template was developed.

The site visits aimed to highlight and share examples of good practice, identify areas requiring improvement and action, and examine the extent to which service user and family voices are systematically embedded in service design, delivery, and governance processes. Due to the constrained delivery timeframe, pre-planning opportunities were restricted resulting in teams being assembled based primarily on individual availability. Although the visits did not have consistent panel members for every site, this had the advantage of bringing wider experiential assessment to the thematic analysis. In addition, within the timeframe it was not possible to ensure safeguards and patient confidentiality processes were in place and therefore a decision was made not to involve service users in visits unless directly identified by the Health Boards. Team members reported that visits were more insightful when service users participated.

A thematic analysis approach was used to assess the evidence from the 15 steps and template feedback. Pattern recognition from experiential observations and narratives is a recognised method of thematic analysis[13]. Two approaches to theming pattern recognition were taken. During each site visit, the team met to discuss experiences and to note patterns on the template as well as individual experience data. This ensured that group experiences were reflected. The panel met again with the collated data from the template and again noted pattern recognition from the collated templates and site visit experiences. These themes were then summarised, with examples of strengths and development needs. Examples of reliable good practice for sharing nationally were noted. Overall themes for national improvement consideration were also noted.

Analysis of overall findings and identification of recommendations

Findings from each workstream are presented in detail in separate sections, each written by the panel member who led the work. Synthesis and analysis of all the findings involved a process where panel members reviewed all the findings, supported by a structured, evidence-based framework that identified seven components of a quality maternal and newborn health system (Table 1)[6]. By interrogating the findings of each workstream in regard to each of these seven components, the strengths, problems and gaps were identified. All panel members discussed the findings together in a face-to-face meeting. Further analysis was led by the Chair and one panel member in a process that involved input and confirmation by all panel members; final analysis is described in Section 8. Recommendations for action were directly informed by this analysis, and all were agreed by all panel members (Section 9).

Table 1: Key conditions for maternal and newborn care and services in all settings, used to inform analysis of the findings of this assessment[6].

Key conditions for maternal and newborn care and services in all settings		
1	Core focus on respectful, individualised care services and partnership working for all women, babies, families across the whole maternity journey	• Reaching all women, babies, families without exception • Listening to women, building trust, strengthening women's own capabilities • Evidence-based information, discussion, education • Listening to communities to understand their needs and resources
2	Meaningful participation of women and babies, families, communities, staff	• In design, planning, provision, monitoring and review of care, services, education and training • Equity of inclusion to ensure all voices are heard
3	Integration of evidence-based standards, services, and education across the continuum of care and all disciplines and settings	• Consistent evidence-based standards, policy, practice • Respectful interdisciplinary team working with shared purpose • Continuity of care across the whole maternity journey, in all settings, between all disciplines
4	Enabling environment, psychological safety for all staff and students	• Culture of respect, mutual support, kindness • Shared values • Safe staffing levels • Student voice • Interdisciplinary education and training • Management and leadership development
5	Whole-system support for universal, whole-continuum accountable, knowledgeable, skilled, kind midwifery	• In hospital and community settings • Meeting NMC standards of proficiency for midwives

Key conditions for maternal and newborn care and services in all settings		
6	Sturctures, processes, and resources to assure whole-continuum, evidence-based planning, monitoring, governance and commissioning	• Funding that covers the required staffing establishment for all settings • Informed by evidence-based infromation and evaluation of services • Access to timely and reliable data on outcomes and experiences • Clear lines of accountability • Commissioning processes based on standards and evidence of impact
7	Political will, evidence-informed policy directions for safe, equitable, quality maternal and newborn system with ongoing commitment	• That promotes and supports a safe, sustainable, equitable, quality maternal and newborn system with adequate resources

Limitations of the assessment

The work was conducted over a limited time period from September 2025-January 2026 so all workstreams had to scope the work accordingly. We judged that this timing precluded effective analysis of case file audits. Poor weather conditions, including severe winter storms, led to a small number of in-person engagement sessions and site visits being cancelled and rearranged or moved online. The very large number of supporting documents submitted by Health Boards (over 4000), meant that we were not able to analyse each of these line-by-line, but instead employed sampling methods.

Section 3: Context

Table and Figure numbers prefixed with an E are included in Appendix E

The context of maternity and neonatal services in Wales

This section provides an overview of population data, the configuration of maternity and neonatal services, workforce information, aspects of care provision and outcomes for women and for babies. In addition, an analysis of the recommendations from previous reports and reviews relevant to Wales is presented, and key themes are identified.

Population

The population of Wales is around 3.2 million, with recent annual increases driven by net international and internal migration[14]. People live in urban, semi-rural and rural communities. Cardiff is the capital city, with around 12% of the population. The mountainous geography that characterises much of Wales has a direct impact on transport links and the provision of health services.

The age distribution of the population is changing. There are an estimated 598,848 women of childbearing age (15-45 years), a slight decrease since mid-2011. However, that number is estimated to increase by around 40,000 by 2035[14]. Women of childbearing age are predominantly reported as of White ethnicity (91.5%) in the 2021 census, with the largest global majority represented by Asian communities[15]. It is likely however that the Census figures underestimate some minority populations, especially migrant communities.

The extent and distribution of deprivation using the 2025 Welsh Index of Multiple Deprivation (WIMD) measure is shown in Figure F1. 19% of women were classed as materially deprived (compared with 12% of men), and women of childbearing age were over-represented in the most deprived communities. Wales exhibits a significantly more deprived profile compared with England and Scotland, with only seven percent of the population residing in the least deprived quintile of areas across the UK[14; 16; 17].

Health services

Figure 1 displays health services across Wales which are provided by seven Health Boards. All Health Boards provide maternity care; Powys Teaching Health Board only provides midwifery led care as a result of its very rural nature and absence of a district general hospital. Six provide neonatal care; three neonatal intensive care units (NICUs) provide care for the smallest and sickest babies. There is one Sub-regional Neonatal Intensive Care Centre (SuRNICC), and five Special Care Baby Units (SCBUs).

Figure 1: Map of perinatal services across Wales.

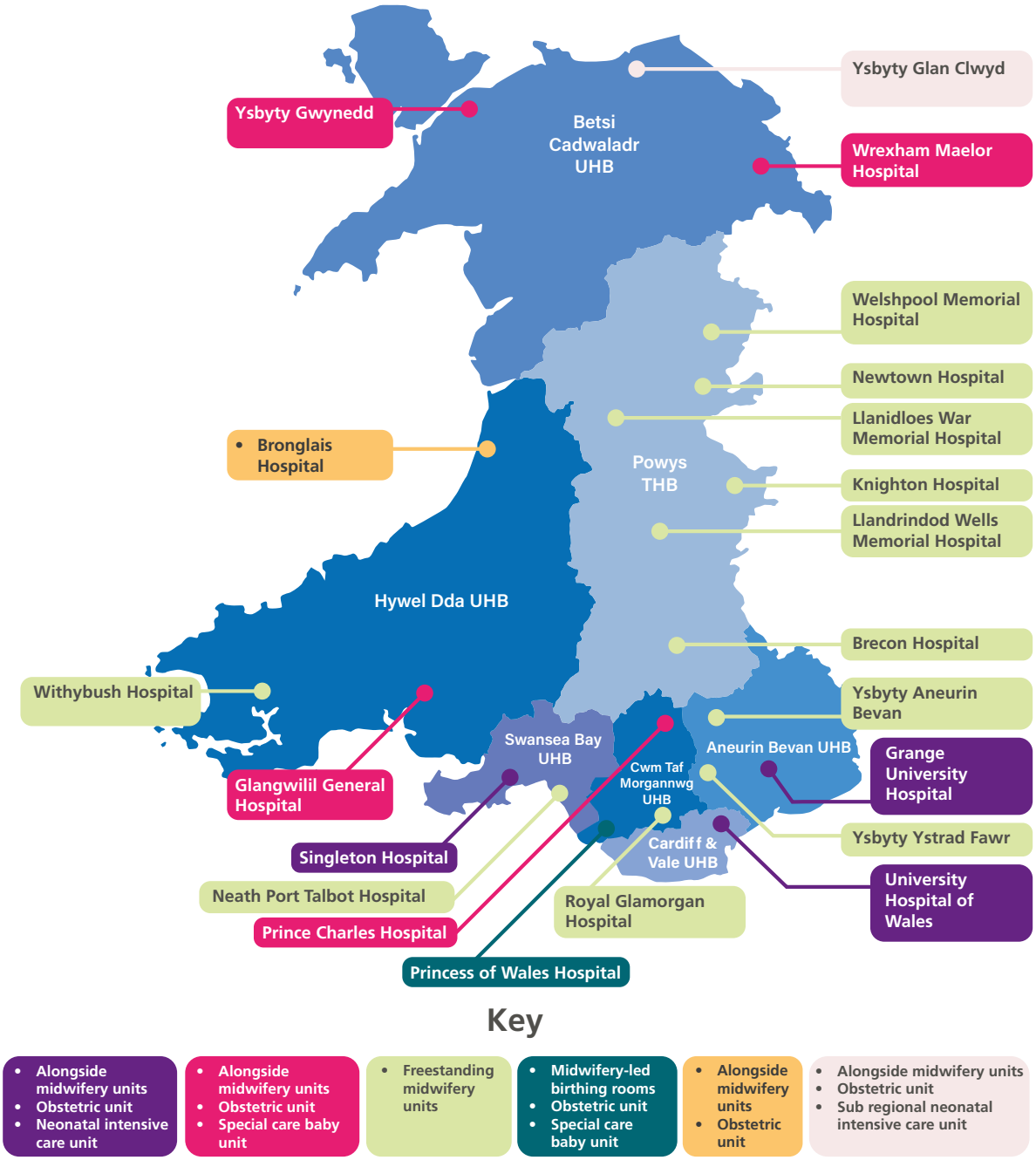


Table 2 shows the number of registered births by Health Board of residence and by Health Board provider. The mountainous, rural geography of Wales requires significant cross-boundary working, with women and babies moving across Health Board boundaries and in some cases to hospitals in England. This cross-boundary working explains the discrepancy between births by Health Board of residence and Health Board provider[18, 19].

Table 2: Total registered births by Health Board of residence and Health Board provider, 2024.

Health Board	Health board of residence	Health Board provider
Betsi Cadwaladr University Health Board	5,605	5,220
Powys Teaching Health Board	926	175
Hywel Dda University Health Board	2,935	2,769
Swansea Bay University Health Board	3,236	2,994
Cwm Taf Morgannwg University Health Board	3,884	4,173
Cardiff and Vale University Health Board	4,776	4,952
Aneurin Bevan University Health Board	5,589	5,265

Health service structures

Organisations in Wales with responsibility for service commissioning, data collection, education, quality improvement, maternity safety and learning, and regulation of maternity and neonatal services include:

Welsh Government

The Welsh Government provides national leadership and strategic direction for maternity and neonatal services across Wales. It sets policy priorities, allocates funding, and works to ensure that services align with wider health objectives, such as improving quality, safety, and equity of care. Working with NHS Wales Performance and Improvement and other bodies, the Welsh Government oversees implementation of clinical guidance, monitors progress against national standards and drives system-wide initiatives to reduce variation and improve outcomes for mothers, babies, and families.

NHS Wales Performance and Improvement

The NHS Wales Performance and Improvement (NHS P&I) became operational on 1st April 2025. It is hosted by Public Health Wales NHS Trust and works on behalf of the Welsh Government. The overall purpose of NHS P&I is to drive improvements in the quality and safety of care to enable better and more equitable outcomes, access and patient experience, reduced variation, and improvements in population health.

The National Strategic Clinical Network for Maternity and Neonatal Services

The National Strategic Clinical Network for Maternity and Neonatal Services became part of the NHS Executive from 1st April 2023, which then became NHS Wales Performance and Improvement in 2025. This was one of the first networks along with the Scottish Perinatal Network, within the UK to cover both maternity and neonatal services, providing support for a single perinatal service.

NHS Wales Joint Commissioning Committee (JCC)

The JCC is responsible for the joint planning of specialised and tertiary services on behalf of local Health Boards. The JCC commissions neonatal transport, neonatal intensive care (IC) and high dependency (HD) cots for the South Wales area, fetal medicine, including fetal cardiology, and adult congenital heart disease which supports a clinic for pregnant women.

Digital Maternity Cymru (DMC)

Following an initial project phase to determine need, all Health Boards are expected to implement a digital system for maternity services, BadgerNet® Maternity, by March 2026. This will be overseen by Digital Health and Care Wales. BadgerNet® is already in place for neonatal services.

Health Education and Improvement Wales (HEIW)

HEIW is the strategic workforce body for NHS Wales. They recently published the Strategic Perinatal Workforce Plan. They are also the Statutory Education Body commissioning undergraduate nursing and midwifery education and training from Welsh Higher Education Institutions (HEIs) and are responsible for the Post Graduate Medical Deanery.

Welsh Risk Pool (WRP) Maternity Safety and Learning Programmes

Welsh Risk Pool is part of the NHS Wales Shared Services Partnership's Legal and Risk service. It enables all Trusts and Health Boards in Wales to indemnify against risk by integrating risk assessment, claims management, reimbursement and learning to improve patient safety and outcomes. It supports perinatal services through PROMPT Wales (Practical Obstetric Multi-Professional Training), Community PROMPT Wales, Intrapartum Fetal Surveillance Wales and MoNET Wales (multiprofessional neonatal emergency training) programmes.

Healthcare Inspectorate Wales (HIW)

HIW is the regulator of independent healthcare and the inspectorate of NHS healthcare in Wales. In 2020 HIW conducted a review of all maternity services in Wales to explore the quality and safety of the care being provided. Following the publication of the report, all-Wales recommendations were circulated, and each Health Board submitted an action plan to address the improvement areas. Each plan was individually reviewed by HIW to ensure each Health Board was taking action to make improvements and protect service users from any risks identified. HIW continues to monitor progress in this area with re-inspections of some maternity services to take place, to ensure timely improvements are being made. To date, HIW have not undertaken any reviews of neonatal units in Wales.

The Welsh Ambulance Service University Trust (WAST)

WAST plays a significant role in supporting maternity and neonatal services. In 2024 the service responded to 2298 maternity incidents and recorded 249 births. WAST staff take part in multidisciplinary PROMPT training and a programme of training on newborn care has been implemented in the last two years. The service has a Specialist Midwife to lead on safety and quality as part of the Maternity and Neonatal Safety Support Programme[1]. This postholder has led on a number of improvement projects.

Perinatal service workforce, education and training

Workforce data

Information about the adequacy of workforce numbers and skill mix is limited; appropriate benchmarking data are not available for comparison with other jurisdictions, and there is no information available about staffing levels and skill mix in relation to the care required by childbearing women and babies.

Medical workforce numbers

Full time equivalent (FTE) numbers of medical staff working in maternity and neonatal care including obstetrics, paediatrics, and anaesthetics (currently 166.5, 238.2 and 460.7 respectively) have increased consistently over time, representing a total rise of 32.5% since 2015. These professional groups cover other services and the amount of time they spend in maternity and neonatal care is not known. Age distribution indicates that the majority are over 40 years old.

Midwives and maternity support workers

Full time equivalent numbers of midwives show an increase of 189.6 since 2015 (currently 1614.6), an increase of 13.3% (**Figure E2**). The majority are midwives employed at Band 6 (33.3%). 4.8 percent are senior midwives at Bands 8 to 9. The age distribution has shifted significantly since 2015 with a shift towards a younger workforce (**Figure E3**). This shift in age is further supported by an increase in the number of midwifery student places commissioned (**Figure E4**). While this is a positive indication of continuing interest in working in midwifery, it also indicates a less experienced workforce. The marked increase in student places commissioned (more than doubling since 2016) while a positive step is likely to increase stress on placements and on clinical midwives, since students spend 50% of their time in clinical practice. The proportion of Band 8 and 9 midwifery posts (4.8% of the total midwifery workforce) is lower than the proportion of similar posts in neonatal nursing (7.1%), although the data are not strictly comparable (see below re neonatal nurses).

Monthly sickness rates for midwives rose substantially in early 2021 to around 9% (Figure E5). They have gradually fallen since mid-2023 and in July were 6.3%. Anxiety/stress/depression is the most common reason for sickness absence (37.8% of the reasons given) (Table E1).

Neonatal nurses

There has been an increase of 24.1% in the number of full time equivalent neonatal nurses since 2015, to a current total of 508 (**Figure E6**). The majority are at Band 5, but there is a higher proportion (7.1%) of senior posts (Bands 7, 8 and 9) than in midwifery (**Figure E7**). The age distribution shows a younger workforce overall than in 2015, but there are proportionately more in the 35-39 age band than midwives. While this could potentially indicate a more experienced workforce, many of those on senior bands will be in Advanced Neonatal Nurse Practitioner roles (ANNPs) and on the Tier 1 medical rota, so will not be acting in leadership roles in nursing.

Monthly sickness rates for neonatal nurses reached a high of 10.4% in early 2022; in July 2025 they were at 8.5% (**Figure E8**). Again, anxiety/stress/depression is by far the most common reason for sickness absence (38.2% of the reasons given) (**Table E2**).

Multidisciplinary training

Limited information is available about multidisciplinary education and training; what is available relates to training for emergencies. Information about other aspects, for example on leadership development or quality improvement, is lacking.

Rates of completion of PROMPT training by multidisciplinary staff are high: 97% or over in four Health Boards with the other Health Boards achieved rates of 88-89% (**Table E3**).

Rates for intrapartum fetal surveillance training were also reported as high, with two Health Boards achieving 97% or over, two achieving 90 or 91%, and the remaining three achieving 80-83% completion rates. (**Table E4**).

Service user involvement

Information about service users' involvement in the planning, provision and monitoring of maternity and neonatal services is limited. The primary mechanism is through Maternity and Neonatal Voices Partnerships (MVNPs) at Health Board level. MVNPs are independent groups bringing together service users and health professionals to review and improve maternity and neonatal services, ensuring women's voices are central to service development. The Chair should be a service user. There are indications that MNVPs are currently not fulfilling their potential, however. Five Health Boards have MNVPs, but only two have remunerated positions for the service user Chair. Three of these have regular meetings, though the number attending the meetings vary.

UNICEF UK Baby Friendly Initiative accreditation

The UNICEF UK Baby Friendly Initiative[20] standards aim to promote close and loving relationships between parents and babies and to ensure staff are able to provide families with evidence-based information to make informed choices about feeding and caring for their baby. The staged accreditation process has interlinked, evidence-based standards for maternity, neonatal, community and hospital-based children's services, and universities. Accreditation stages run from Registering Intent, Certificate of Commitment, three stages of accreditation with regular re-assessment, to the highest level, a Gold Award. One Gold Award has been achieved in Wales, by Bangor University's midwifery programme. Data provided by UNICEF UK[20] indicate:

Table 3: UNICEF UK Baby Friendly Initiative accreditation in Wales, January 2026. Source: UNICEF UK Baby Friendly Initiative 2026

Service / programme	Status	Number of services / programmes
Maternity Services	Full accreditation & re-accredited	3
	Require further assessment	1
	Stage one acredditation	1
	Overdue for reassessment	3
Neonatal Services	Stage 2 accreditation	1
	Require further assessment	3
	Registered intent	1
	No current information	2
University Midwifery Programmes	Gold award	1
	Stage 1 accreditation	2
	Certificate of commitment	1
University SPCHN Programmes	Registered intent	1
	No current information	3

Characteristics of childbearing women and babies

Pregnancies and births

The total number of births in Wales in 2024 was 26,951, having declined by 14.2% from 31,412 in 2018[18]. This downward trend reflects patterns seen across the UK; the total number of infants born in England has declined by approximately 9.2% over the same period. Births to women in the most and second-most deprived quintiles accounted for over 40% of all births in 2024. Sixteen percent were to mothers born outside of the UK; this compares with 34.7% in England. There was wide variation between local authorities (e.g. 36.2% in Cardiff local authority)[21].

Over a third of women (38.5%) were pregnant with their first baby (9,390/24,395), with the remainder having their second or subsequent babies (**Figure E9**). Almost 34% were aged between 30 and 34 – an increase from 28.3% in 2016 – and more than 21% were over 35. Fewer women in younger age groups were giving birth, with the steepest decline in those aged under 25: 16.9% compared with 23% in 2016[22]. Teenage conception rates have seen a significant decline in the past 15 years, from 38.6/1000 under 18s in 2009-11 to 15.7/1000 in 2020-2022[23].

The rate of preterm births (36 weeks and under) in 2024 was 7.9%[22], demonstrating no change since 2016.

There was a 39% increase in the rate of termination of pregnancy in the six years to 2022, perhaps reflecting a change in legislation during the Covid-19 pandemic to enable early terminations at home, and perhaps reflecting the impact of poverty or the availability of family planning support. Rates vary widely by Health Board with Cardiff and Vale having the lowest rate[24].

Initial assessment: maternal BMI, mental health, and smoking

Around 77% of pregnant women had their initial assessment carried out by 10 weeks of pregnancy in 2024[25]. At this appointment 32% of women were recorded as having a Body Mass Index (BMI) of 30+ in 2024, compared with 26.2% in 2016[26]. Over 31% reported a mental health condition in 2023, increased from 19.5% in 2016[27].

A positive trend has been the decline in the proportion of women smoking at initial assessment, around 13%, down from 19% in 2016[28]; a further 17% of those still smoking stopped during pregnancy[29].

Outcomes and processes for women and babies

Maternal mortality

Maternal mortality rates are monitored by the UK-wide 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries' programme[30]. Data on maternal mortality are combined across the UK, with numbers in Wales too low to report separately. The three-year rolling average of direct maternal mortality rates per 100,000 maternities increased between 2012-14 and 2020-22, with a small decrease to 5.74 in 2021-24[30]. This increase remained significant when deaths due to Covid-19 were excluded.

Maternal mortality rates are strongly related to ethnicity and deprivation (Figures 2 and 3). In England, women of Black, Asian and Mixed ethnicity have substantially higher mortality rates than women of White and Chinese ethnicity; numbers are too low in Wales to report separately. There is a direct relationship between deprivation and maternal mortality. While there is an increase in maternal mortality rates all socio-economic groups, rates in the most deprived group (18.10/1000 maternities) are more than twice those in the least deprived (8.90/1000) and substantially higher than second least deprived (10.10/1000) groups.

Figure 2 Maternal mortality rates per 1,000 maternities, by ethnicity, England, 2012/14 to 2022/24. Source: MBRRACE-UK.

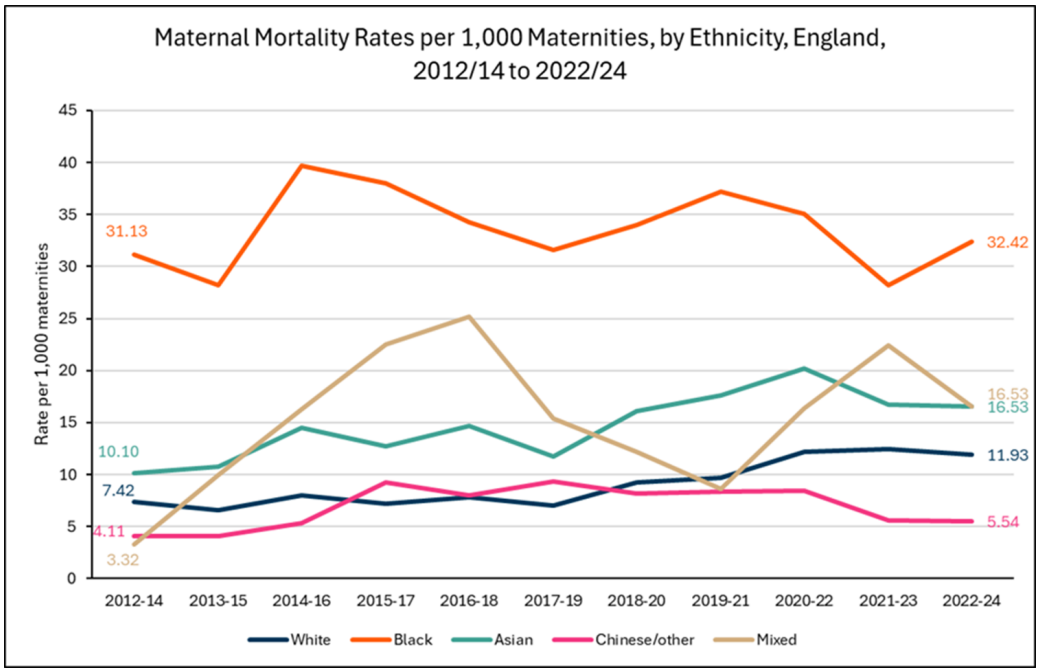
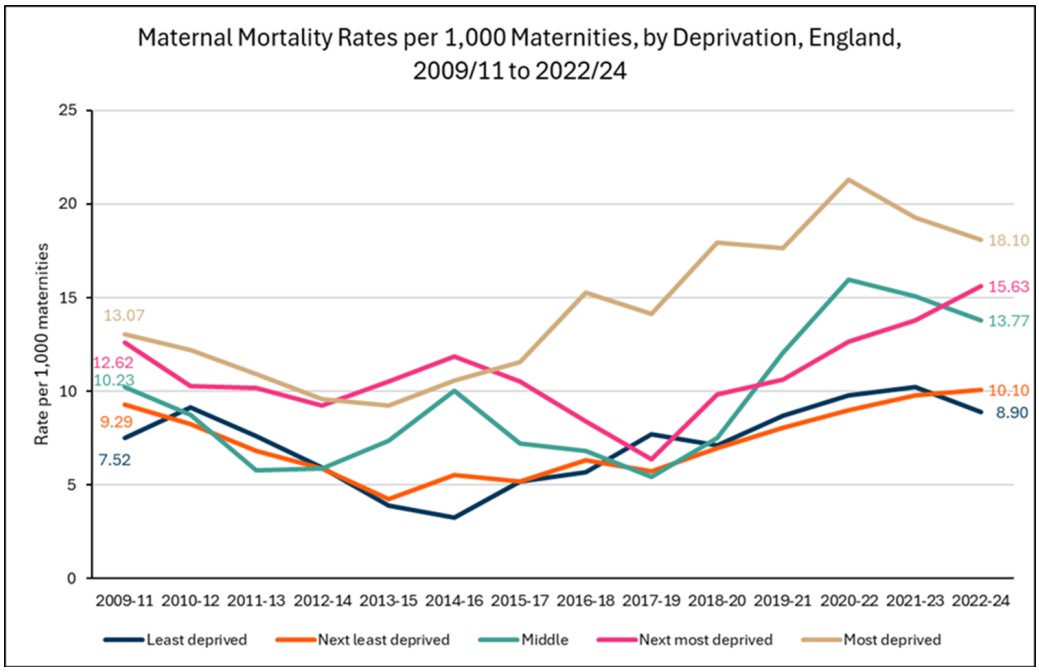


Figure 3: Maternal mortality rates per 1,000 maternities, by deprivation, England, 2012/14 to 2022/24. Source: MBRRACE-UK.

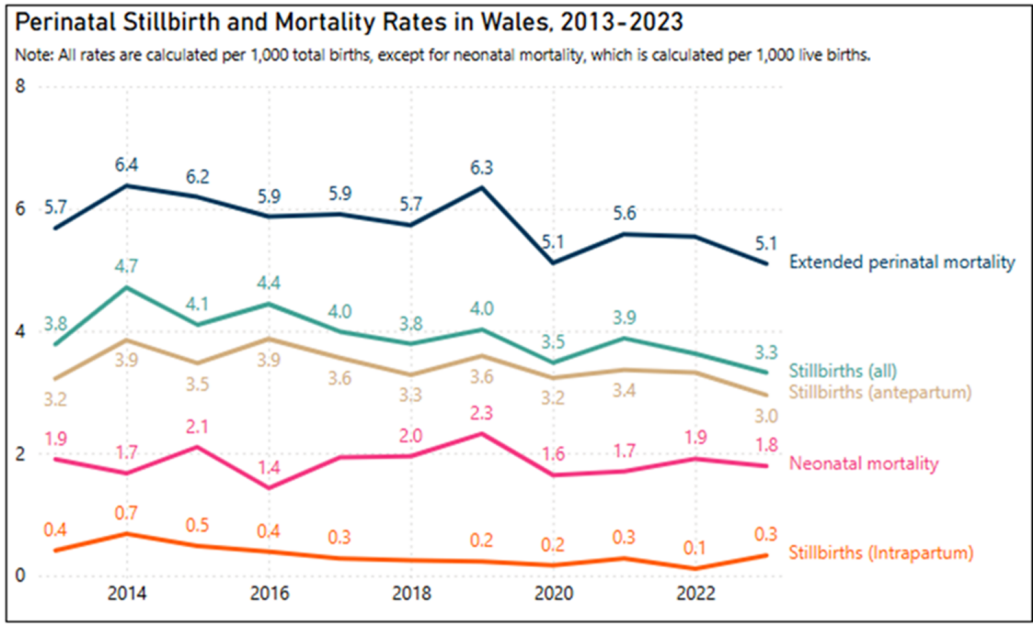


Perinatal mortality

Stillbirth rates declined in Wales from 4.7 per 1000 births in 2014 to 3.3 in 2023. This demonstrates a downward trend over the past 10 years, but rates in Wales remain the highest in the UK[30] and there has been no improvement in intrapartum stillbirth despite increasing interventions aimed at improving this, similar to other UK countries[30].

Neonatal mortality increased for the most preterm babies but decreased for those born at 32 weeks or later[32]. Wales had the highest rate of neonatal deaths in the UK in 2023 (1.79 per 1000 births)[30].

Figure 4: Perinatal stillbirth and mortality rates in Wales, 2013 -23. Source: MBRRACE-UK.



Despite an overall decline in stillbirth rates across the UK, significant ethnic inequalities persist. Babies born to women from Asian and Black ethnic groups experience substantially higher mortality rates than those born to White mothers. Neonatal mortality rates for babies born to mothers living in the most deprived areas of the UK increased for a third consecutive year and are now around twice as high as those babies born to mothers from the least deprived areas[30].

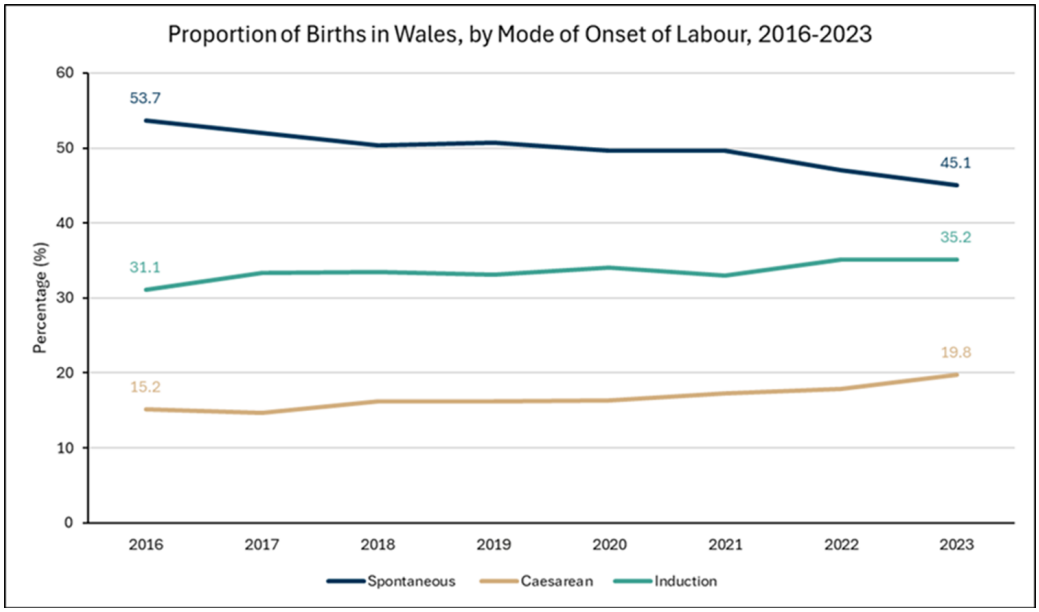
Onset of labour

The proportion of women having a spontaneous onset of labour has fallen steadily since 2016, from 53.7% to 45.1 in 2024, similar to the pattern in England (**Figure E10**). While induction of labour rates rose slightly to 33.2% in 2024, the biggest increase in non-spontaneous onset of labour rates was in planned caesarean birth (22%).

Mode of birth

Rates of spontaneous vaginal birth have also declined since 2016, from 63% to 54% in 2023, also reflecting trends seen in other UK countries (**Figure E11**) . The main contributor to this is the rise in caesarean birth, both planned and unplanned, to a total of 35.2% in 2024 (19.8% unplanned caesarean birth). Around a third of women having induction of labour subsequently had a caesarean birth (29.2% in 2023), similar to data from other UK countries.

Figure 5: Proportion of births in Wales, by mode of onset of labour, 2016-2023. Source: Maternity Indicators Dataset (MIDS).



Mode of birth rates were not related to deprivation (Figure E12) but there is an association with parity (Figure E13). Women having their first babies are more likely to have an unplanned caesarean birth, or instrumental birth with forceps or ventouse. This indicates that caesarean birth rates will continue to rise in the future as repeat caesarean births are more likely than vaginal births following caesareans[31].

Postnatal outcomes for women

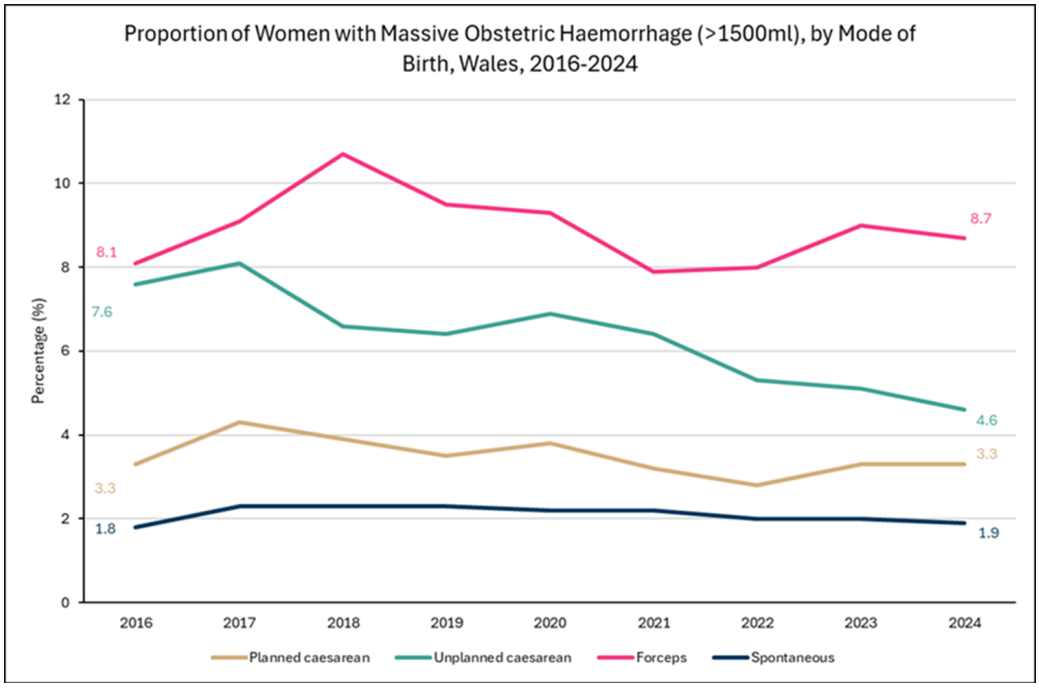
Caesarean surgical site infections rose in the final quarter of 2024 to 4.69% per 100 procedures (**Figure E14)**.

Women having a forceps birth were most likely to experience third- or fourth-degree perineal trauma; 5.54% compared with 3.06% for women having a spontaneous vaginal birth (**Figure E15**).

Rates of massive postpartum haemorrhage (over 1500mls) were highest in women having a forceps birth (8.7%) and unplanned caesarean birth (4.6%), and lowest in women having a spontaneous vaginal birth (1.9%). Rates following unplanned caesarean have fallen since 2016 when the rate was 7.6%.

Note: data on ventouse births for both these outcomes have not been included due to small numbers.

Figure 6: Proportion of women with massive obstetric haemorrhage (>1500ml), by Mode of Birth, Wales, 2016-2024. Source: Maternity Indicators Dataset (MIDS)



Data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team

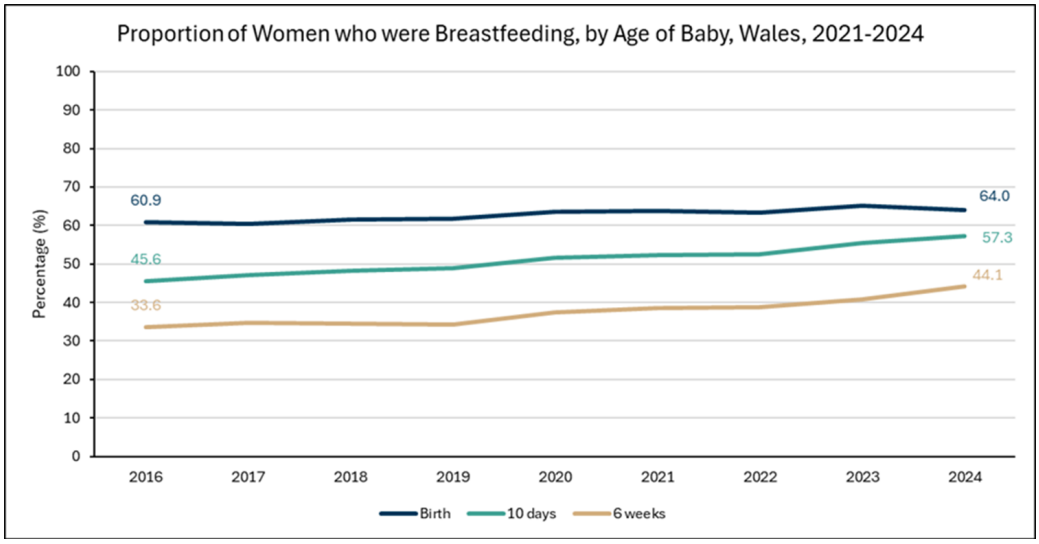
Postnatal outcomes for babies

The rate of moderate to severe hypoxic-ischaemic encephalopathy (HIE) is 1.55 per 1000 live births, a rate that has been relatively unchanged since 2021 (**Figure E16**).

Breastfeeding

The proportion of women who were breastfeeding has risen slowly since 2016 from 60.9% to 64%. While the rates of any breastfeeding at 10 days and at 6 weeks following birth show a steady increase (now at 57.3% and 44.1% respectively), the rapid discontinuation following birth, especially in exclusive breastfeeding, remains evident (**Figure E17**). Rates remain very socially patterned and are strongly related to deprivation, ethnicity, and age; rates are lowest among women living in the most deprived circumstances (**Figure E18**), those of White ethnicity (**Figure E19**) and those under age 20 (**Figure E20**). This may help to explain why breastfeeding rates in Wales are lower than in England (**Figure E21**), which has lower rates of deprivation and higher rates of Asian and Black ethnicity overall.

Figure 7: Proportion of women who were breastfeeding, by age of baby, Wales, 2021-2024. Source: National Community Child Health Database (NCCHD).

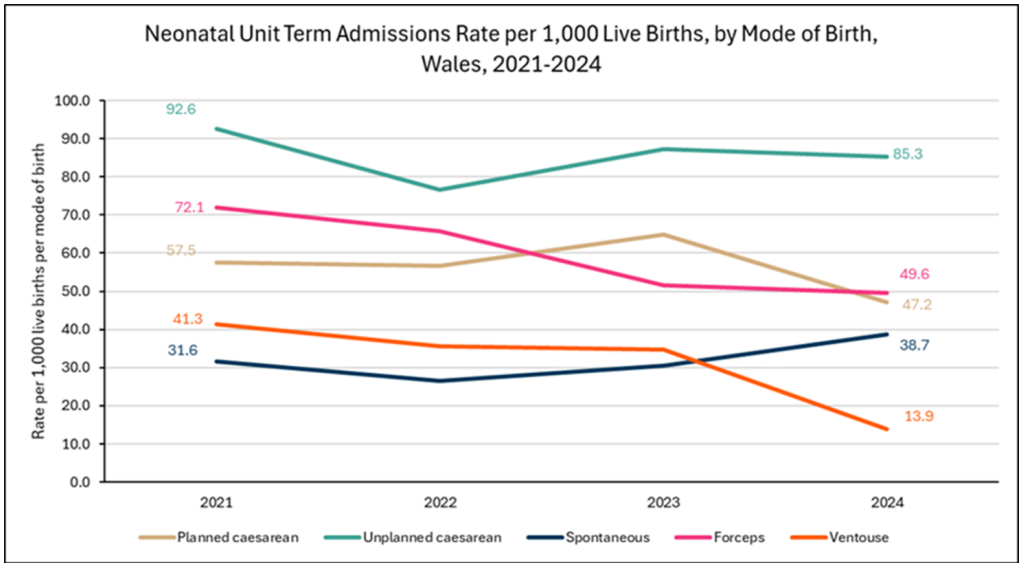


Neonatal care

Neonatal admissions

The rate of babies admitted to neonatal units (124.4 per 1000 live births) has remained constant since 2021 (Figure E22), although the actual number has fallen from 3234 to 3112 because of the decline in the birth rate (Figure E23). Just over 30/1000 of these were babies born below 32 weeks' gestation, with 36.5/1000 at 32-36 weeks' gestation. The remainder were term (37 weeks and over) admissions (45.7/1000) (Figure E24) Babies born by unplanned caesarean and subsequently admitted to the neonatal unit were over-represented; 85.3/1000 babies born by caesarean, compared with 38.7/1000 babies born by spontaneous vaginal birth.

Figure 8: Neonatal unit term admissions rate per 1,000 live births, by mode of birth, Wales, 2021-2024. Source: Neonatal and Maternity Indicators Dataset (MIDS)



Data extracted & analysed by NHS Wales Performance & Improvement Data & Analytics team.

Cot occupancy and neonatal nurse staffing levels

Indicators of neonatal cot and maternal bed availability for the South Wales Network in October 2025 (**Figure E25**) demonstrate that for over 18% of the month the escalation status was red or black, the highest levels of escalation. It achieved green or yellow status on 38.7% of the month. To note, there are five levels of escalation. Equivalent data for North Wales are not available.

The proportion of neonatal nursing shifts that were numerically staffed according to BAPM guidelines rose from a low of 75.5% in 2017 to 89.9% in 2024 (**Figure E26**).

Quality indicators for neonatal care

The National Neonatal Audit Programme compares Wales performance on a range of quality measures with other UK networks - 2024 data (**Figure E27**) demonstrates areas where Wales performed significantly better than other networks (two standard deviations above the overall proportion). These were: more babies born less than 34 weeks' gestational age who were receiving their own mother's milk at day 2; more babies born less than 30 weeks' gestational age who received a medical follow up at two years' corrected age; and more babies born less than 32 weeks' gestational age who received effective treatment of necrotising enterocolitis (NEC).

Areas where Wales performed significantly worse than other networks included: fewer babies born at less than 34 weeks' gestational age receiving any of their own mother's milk at discharge home; fewer babies born at less than 31 weeks' gestational age undergoing screening for retinopathy of prematurity according to the guideline; and fewer babies born at less than 32 weeks' gestational age receiving only non-invasive breathing support during the first week of life.

Other measures of perinatal optimisation show improvement broadly in line with improvements in other networks including a marked increase in deferred cord clamping for babies born at less than 34 weeks (increased to 73.5% in 2024 from 26.1% in 2017) (**Figure E28**). Other measures – including fewer bloodstream infections for babies at less than 32 weeks (3.5% in 2024) (**Figure E29**), intraventricular haemorrhage in babies born at less than 32 weeks (Figure E30) and the proportion of babies born at less than 32 weeks who develop bronchopulmonary dysplasia or die, remain unchanged since 2017 (**Figure E31**).

The proportion of parent consultations that took place within 24 hours of the baby's admission is relatively unchanged since 2017 (93.3% in 2024) (**Figure E32**).

Analysis of recommendations from previous reports and reviews

Over the past decade, maternity and neonatal services in Wales have been examined through multiple reviews, inspections, investigations and thematic reports. Each of these sources — whether prompted by national learning, regulatory processes, family experiences or external scrutiny — has generated recommendations intended to support improvement. Individually, they offer valuable insights. Taken together, however, the 500+ recommendations have created a vast, uneven landscape that is difficult from decision-makers, staff, and the public to interpret as a cohesive whole.

This fragmented picture presents several challenges. Recommendations accumulate across time and organisations, often highlighting similar issues in slightly different ways or using different language. Themes reappear but are dispersed across multiple documents. Some recommendations are highly specific to individual cases or contexts; others are broad and conceptual. Without synthesis, it becomes difficult for the system to distinguish what is foundational from what is peripheral, what is urgent from what is aspirational, and where national action is most needed. These risks obscuring what is essential, contributes to improvement fatigue, and makes it impractical to prioritise and measure sustained improvement.

The structured synthesis of recommendations conducted for this assurance assessment has identified and summarised the critical factors and the key gaps. A consistent picture has emerged. Recommendations were most related to points where care has come under pressure, where harm or risk has been identified, or where system reliability has been tested. As a result, recommendations were weighted toward clinical safety, assurance, governance, planning and learning. For example, there are numerous and repeated recommendations relating to:

- Serious incident investigation and response (e.g. requirements for investigation processes, review panels, learning following harm)
- Escalation and clinical risk management (e.g. escalation pathways, fetal monitoring concerns, recognition of deterioration, emergency decision-making)
- Governance, assurance and oversight (e.g. audits, assurance mechanisms, reporting structures, compliance with national standards following adverse events)
- Management of complexity and high-risk care (e.g. high-risk pregnancy pathways, neonatal intensive care responses, multidisciplinary review of complex cases)

Structural pressures and the wider conditions in which care is delivered were recognised as the critical constraints, rather than the attitudes of staff. This was also recognised in regard to continuity, compassion, dignity, communication, equity, and women's involvement in decision-making; staff were seen to value these but there were system-level barriers to their consistent implementation. Barriers included:

- Widespread problems with workforce capacity, wellbeing, psychological safety, and sustainability
- Operational and pathway complexity
- Governance, escalation, leadership, and learning in a pressured system
- Differences in digital maturity, estate configuration and service design

By using recognised quality frameworks to examine the recommendations, aspects of care and services that the national recommendations have not addressed, but which have an impact on safety and quality, were identified. These included:

- Universal, equitable, skilled care delivered routinely across the whole continuum of care, predominantly by midwives, is unlikely to appear in recommendations resulting from reviews of failures in care. This may have the unintended consequence of shifting resources away from this essential aspect of care and in practice reducing women's access to prevention, support, and information, thereby compromising safety

The importance of whole-system integration, coherence and alignment, and mechanisms for achieving this, have not been clearly identified. Without this, implementation of effective, large-scale change to tackle structural barriers and enable organisational and behavioural change cannot happen.

Section 4: Our Engagement with Women, Partners, Parents, Families and Communities

Introduction

This chapter captures the experiences, insights and priorities of women, partners / parents and families through two different routes. The first was a national perinatal survey, with data collected from March to August 2025. This provides feedback across four phases of maternity experience, from 20 weeks' gestation to eight weeks post-birth, as well as a fifth survey for parents whose baby received care on a neonatal unit.

Alongside the survey we conducted conversations with over 200 family members. These provided an opportunity to listen in-depth to mothers, partners/fathers, and in some cases grandparents. Our conversations were held in a variety of community settings and during several site visits. As a result, we were able to hear from a wide range of people, including those from the most deprived areas and from different parts of the global majority.

The families we met were given an opportunity to speak openly and anonymously. Many spoke positively about their care. Alongside their feedback, we heard from families who were left unhappy and wanting to contribute to the Panel's assessment so that improvements could be made. Both the positive and negative need to be heard and understood. Families who have had tragic outcomes or otherwise report significant concerns have been at pains to tell us of the good aspects of their care. The readiness of these families to do so adds power to what they say about the negative parts of their experience because it shows the objectivity and balance, they are bringing in their contributions.

Both Positive Feedback and Serious Concerns

National Perinatal Experience Measures

The national perinatal experience measures (implemented from March 2025) provide a real-time picture of how people across Wales are experiencing care from pregnancy through the early postnatal period. The measures are collected in four stages of the maternity pathway, with an additional neonatal survey for women and families that have used neonatal services. Together, they ask about the extent to which services are supporting communication, informed choice, listening, compassion, dignity and overall satisfaction.

The results from the national perinatal survey show predominantly positive feedback for each of the four phases. For example, over 70% of respondents said that they were always listened to during the first phase (20 weeks of gestation) while 2% said that they were never listened to. The comparable figure for the second phase (36 weeks of gestation) was nearly 65% and for the third phase (three weeks post birth) was 73%. For the fourth phase (eight weeks post birth) the level was 59%, with 4.5% saying they were never listened to. For women and families whose babies were admitted to a neonatal unit, 79% felt that the neonatal team caring for their baby listened to them.

Across all phases, most respondents reported being able to communicate in their preferred language. The responses also show that many women who responded to this survey felt supported to make decisions and that they had been treated with kindness and respect.

The volume of responses increases significantly after birth, particularly in phase three which gives a strong sense of how care is experienced during the transition home. Experience scores remain broadly positive at this stage, but the data also reveal a gradual drop in the number of people who said they felt fully listened to or well supported to make choices. This may reflect pressure points around birth, early feeding support and postnatal continuity and highlights areas where services could strengthen relational care.

The number of respondents rating their overall experience is noticeably lower than the number engaging with the specific questions. This gap may indicate that women feel more confident answering focused questions than offering a broad rating of their care, or that some women disengage from the survey when asked for an overall judgement. Despite this methodological caveat, it is concerning that the small numbers who rated their overall care eight weeks after the birth gave notably lower scores, with 40% rating their care as poor or very poor. If this trend continues as this new survey becomes more embedded, it will warrant further exploration and attention.

The neonatal survey, although smaller in scale due to the volume of babies requiring neonatal care, shows that most families felt listened to and treated with compassion by neonatal staff. However, the low numbers of responses to the overall experience question limits how much can be concluded. It suggests work is needed to improve responses rates and understand the experience of families whose babies require neonatal care.

Conversations with Families and Community Groups

In November the panel lead for this workstream attended a Neonatal support group on World Prematurity Day at Princess of Wales Hospital. The event is opened to all who have had a neonatal stay in Cwm Taf Morgannwg University Health Board. Staff also hold a Neonatal Family Engagement Forum bimonthly providing opportunities for parents to share their view. The event was well attended by approximately 15 mothers, fathers, partners and grandmothers. The feedback received was positive regarding the neonatal unit, neonatal nurses and consultants. Families return to this event every year, highlighting that care does not stop at discharge.

Many of the families who spoke with us across Wales reported positive experiences and gave predominantly warm feedback on the personalised care provided by midwives before, during and after birth:

> "A newly qualified midwife listened to me and saw that my baby was ill and was so supportive and advocated for me".
>
> "The midwives during induction and post-partum were excellent".
>
> "My maternity experience was positive, and the midwife was very caring".

Fewer families spoke warmly about their relationship with other medical staff. Some did refer positively by name to individual consultants, including neonatal nurses and neonatologists; and we saw evidence of an ongoing positive rapport between families and consultants at the Dinky Dragons Christmas gathering in Newport, and a community outreach meeting at the Princess of Wales Hospital involving the charity Bliss, which supports families of premature or sick babies.

In Powys, where families were able to compare services either side of the border, the view expressed was that the more personalised care in Wales provided a better experience than more transactional relationships with maternity staff in England.

The community midwifery service provides continuous care for mothers and babies from pregnancy through the first few days/weeks at home. Community midwives offer antenatal checks, support home births, and provide post-birth postnatal care. The focus on continuity and helping families transition until a Health Visitor takes over. Many of the families who spoke with us reported positive experiences and gave predominantly warm feedback on the personalised care provided by community midwives before, during and after birth:

> "Self- referral for the first appointment was great avoiding chasing for an appointment".
>
> "The community midwife was amazing with fantastic follow-up after the birth".
>
> "Staff in RGH on readmission for low weight on day 3 were fantastic, this includes ward staff who helped support breast feeding whilst I waited to go to Tirion".

> "My community midwives were so kind and helpful".

Some of those we engaged with gave overall positive feedback about care provided by staff during their maternity experience (which for some also extended into neonatal care for their baby), without naming staff groups:

> "I can say both my maternity and neonatal experience were positive really".
>
> "I feel that every pregnant woman gets a special treatment, and I can say I felt cared and valued from the staff for the whole time".
>
> "My experience was excellent, I felt supported by hospital staff".
>
> "I was lucky to have an easy birth, supported by the best team ever, and my baby is still breastfeeding"

During our in-depth conversations, families revealed a range of serious concerns. These are highlighted in the rest of this chapter. In almost every conversation we had, the family members and community groups involved indicated that they wanted their experience to serve the purpose of future improvements to help other families. Health Boards should be encouraged that this is the case.

Informed Decisions

Women and other family members spoke of a need for timely and accurate information during pregnancy, birth and afterwards. For example, a mother said that her preference was not to be made aware of the risks of what could go wrong. But the prevailing view expressed was that families should be given more and clearer information at the right time to enable them to take informed decisions about their care. Reflecting this, one woman said:

> "We need to give women evidence of the risks so they can make informed decisions".

Some women told us that they felt pressured into agreeing with decisions about their care which they did not understand. Induction of labour was an example: one woman said that she did not know what induction meant and was given a leaflet after the decision to plan for induction had been taken. Her point was that this did not amount to informed consent.

Several women, a few of them health professionals, told us that they had been able to challenge the medical staff but were conscious that less assertive women did not feel able to do so. One said:

> "Less experienced mothers would not argue with doctors like I could".

Several women commented on the lack of agreement amongst the members of the medical team. One said:

> "In my pre-natal care every appointment was with a different consultant. They all gave me different advice."

When things go wrong

When things go wrong, families expect to be told promptly and not left guessing what may have happened and not wanting to have to depend on the complaints system to secure the relevant information. They need a supportive, trauma-informed, restorative approach.

The lack of a supportive, trauma-informed approach was a common criticism amongst families whose babies had died. Where an investigation was held, more than one bereaved family told us that they had had to chase progress. Where families were invited to meetings, lengthy, complex documents were at times provided with little time to read and understand these before the meeting took place. For some families, this clearly reinforced their trauma and left them bemused as to why the Health Board was not more straightforward and ready to share information. One family shared a harrowing account of their prolonged suffering after their baby's death. They described a lack of postnatal health care for the mother's physical needs, delayed then withdrawn apologies, and a heavily adversarial, legalistic system lasting over three years.

In a wider range of cases not involving the death of a baby, several families pointed to basic errors in their treatment. One example was a mother discovering that her medical notes wrongly described her blood group. Another case involved a mother being discharged from hospital with the wrong baby's notes. In both cases the concern expressed was that the error only emerged through the vigilance of the mother. This reflected a wider point made that hospitals did not appear to families to want to be proactive in revealing what had gone wrong.

The role of fathers

Mothers and fathers said that they wanted fuller involvement for fathers. One father said that:

> "Fathers felt invisible during the whole maternity experience and left out".

A range of examples were given. Some involved the lack of discretion applied in enforcing visiting hours. One mother explained that her partner was obliged to leave within a few hours of her caesarean birth. Others said that they were conscious of the pressures on staff and that if fathers were allowed to stay overnight, they could help to provide practical and emotional support. One illustration was of a new mother who was unable to go to the toilet overnight as she did not want to leave her baby alone.

More generally, we heard that fathers wanted to be more actively involved in supporting their partners and in decision taking. One said that:

> "I learnt a lot from my first experience of fatherhood and could advocate for my partner a lot more [in any future pregnancy]".

Another father pointed to his experience of a disparity, including in the approach of health visitors:

> "The whole maternity process from ante-natal classes to health visitor visits disqualifies and excludes me as a father".

However, for parents who accessed neonatal services the feedback was very positive. One mother and father shared that the care their baby received in NICU was excellent.

> "We were kept informed and the Nurse came with us to the Unit".
>
> "My husband and I were able to visit when we wanted to, and this made a huge difference".
>
> "Maternity services could learn from the practice within Neonatal Services".

The importance of language

A recurring theme in our conversations was the lasting impact on families of casual, offhand remarks or flippant actions from staff. Families went out of their way to acknowledge the pressure on staff, but it is apparent that months, sometimes years later families can still recall the phrases used and the detail of feeling belittled by small moments. A number of families recognised this as being summed up as **"little things, big things"**. In other words, a single remark can have a big impact. Some families described having an almost entirely positive experience of pregnancy, resulting in a healthy birth, which has been spoiled for them by one thoughtless comment.

In one example, a mother said that a "dampener" had been put on her experience as her five-year-old niece had been excluded as part of the first family visit following the birth. The mother recalls being told "she is not allowed in here" and "kids are germ spreaders" and added:

> "My baby's birth was a big moment for our family but was overshadowed by the midwife's reaction and comments"

In another instance, a woman who was having difficulty with breastfeeding and who had no option other than using a bottle was told by a health visitor, "you've given up already". Another woman had a midwife refer to her "failure to breastfeed".

A further account involved a bereavement midwife who, during a phone call, remarked to a woman,

> "You don't sound upset".

In one particularly tragic set of circumstances, a woman who presented with pain and bleeding recalls that she was told she was a "hypochondriac". Tragically her baby was born prematurely and subsequently died.

Another bereaved family related how, when receiving care for their subsequent pregnancy, they were frequently greeted with a cheerful **"Is this your first?"**, despite their previous bereavement being clearly marked at the top of their notes. They suggest that all staff are trained to ask instead, **"Tell me about your family?"**.

Sensitivity to different cultures.

It was important to the panel to listen to the experience of mothers and fathers drawn from different ethnic and faith backgrounds. With the help of the organisations involved, including Eyst, the Women's Advocacy Network in Cardiff and the Chinese Association for Wales, we heard from over 40 people.

We also had the benefit of a submission from the Birth Partner Project in Cardiff which provides volunteer birth partners to offer support and friendship to asylum-seeking and refugee women.

Their volunteers report witnessing:

> "Much high-quality care during long hours that we, as volunteers, have been present at births".

The same submission identifies issues of cultural awareness, consent and language barriers:

> "We have also seen instances of individual sub-optimal care, where women have been treated brusquely, their wishes not heard or in some cases disregarded; there has been some lack of cultural awareness; failure to explain why procedures are being offered; prioritising of hospital procedures over women's needs and a lack of warmth and kindness."

We have heard similar points made powerfully in the meetings we have attended.

Women of Islamic faith shared a common concern around the lack of sensitivity to culture, with several sharing how their basic dignity was not protected. The examples given were being taken into public areas without clothing, not covered up and no offer to have their head covered before being exposed to men. One woman told us:

> "During transfer and care I was left naked for extended periods and had to insist on being covered up. This was not considered by anyone until I insisted".

Those making this point accept that the priority must be patient safety and achieving this in a hospital setting may make it difficult to fully adhere to basic standards of modesty. But within those constraints, several women indicated that they did not feel that the medical staff understood the importance within their culture of making all reasonable attempts to protect their dignity.

Equivalent points have been made to us about Chinese cultural practices, including the importance of new mothers being given hot drinks and not cold water or juices.

We have heard echoes of the point made earlier about a lack of information and understanding, compounded by language barriers. We have heard positive and negative experiences of the challenge involved where the mother does not speak English confidently. One Polish-speaking woman told us that medical staff took care to explain everything clearly to her. By contrast, another woman with English as a second language told us that medical staff used words that she did not understand and did not check with her whether she had understood.

We heard from some women who reported comments made to them by medical staff which made assumptions because of their colour and mode of dress. For example, one British-born woman of Islamic faith was told:

> "This is how we do things in this country".

Another woman said that, when she complained about medical negligence relating to her critically ill baby son, she was told that he was being given better treatment than **"if you were in Pakistan"**. She informed the consultant that she was a British citizen who had never been to Pakistan and asked, **"why were they mentioning it?"**

Support after birth.

In focusing on "avoidable deaths", some previous assessments of maternity care have focused on the medical interventions given before, during and immediately after birth. By talking with women who have experienced a wider range of outcomes, the importance of access to support after birth has figured strongly.

One example is breastfeeding. More mothers have referred to the need for support with breastfeeding than to any other single issue.

Families have revealed the importance to them of two other forms of support. One is the ability to access mental health services. The other is the clear benefits brought about by the existence of a wide range of community groups.

Accessing Mental Health Services

A considerable proportion of mothers and fathers have spoken to us openly about their mental health and need for support. In some of these cases, the women had suffered miscarriages. Mental health has been identified to us as an important pressure point by those involved in perinatal mental health across Wales.

We heard of some families accessing mental health support privately, but more generally that there were significant delays in accessing such support. Several families referred to their experience as "trauma." This covered not only those whose babies had died or where there was an ongoing medical condition but extended to a range of other circumstances. It is not clear from our conversations the extent to which the experience of the birth was a contributory factor, but many mothers and some fathers referred to it in those terms.

One mother expressed this point in this way:

> "There is no support following a traumatic birth or miscarriage. Our experience has left us not wanting another child."

One father, who has established a support group for fathers, spoke about their feelings of loneliness, isolation, anxiety, and concerns about changes in mood and motivation linked to becoming a father. Another father told us:

> "It's hard to get fathers' perspectives on parenthood because lots of men won't talk about it."

Several mothers volunteered information about the impact of becoming a father on their partners' mental health. We heard of examples of new fathers experiencing feelings of anxiety and depression and being unable or unwilling to access support.

Support Provided by Community Groups

We were able to meet mothers and some fathers who were attending a wide range of community support groups. These included groups focussing on breastfeeding; others bringing together the parents of premature babies; playgroups, some arranged and supported by Flying Start; charities; some networks for families drawn from the global majority including Muslim families, refugees and asylum seekers and the charity Sut Mae Dad? (How's Dad?).

These groups were fundamental to mothers and fathers in terms of being able to access support services not provided by the NHS in their cases, such as breastfeeding, mental health, bereavement and counselling support.

It was clear that the groups are meeting an important need and were highly valued by all those we spoke to. For example, one dad said

> "There is lots of provision for parent and baby groups where we live. It is nice to have the opportunity to go to things."

In events catering for families with babies continuing to require neonatal care, we were told how vital it was for this gap to be filled. One mother said that she could not bear to attend a baby and toddler group where parents were "showing off their perfect babies" because that was not her situation, and she was uncomfortable in that setting.

The benefits included the emotional connection those attending made with other parents and extended to practical purposes. One mother told us that she had difficulties with breastfeeding, which busy midwives were unable to assist her with, but was helped by other mothers at a voluntary support group that she later attended. Many other women echoed this point.

Mothers also said to us that they appreciated the opportunities for them to socialise with other mothers, and for their babies to socialise with other children. One mum said:

> "I went to the breastfeeding club every week. There were other mothers there who could support me."

Those attending these groups told us that they had found out about them through Facebook, other social media, and word of mouth, rather than through midwives, doctors, or health visitors. It was therefore unclear whether others who might similarly benefit from these groups were even aware of their existence.

One Mum said:

> "I'm in a breastfeeding WhatsApp group which is how I heard about today's event"**[a Flying Start meeting]**.

Several parents attending some of these groups were concerned about their financial sustainability. Some of the staff or volunteers involved confirmed that their future was indeed precarious.

Section 5: Staff experience

Why Staff Experience Matters

Staff are fundamental to the provision of quality care in the NHS, directly impacting outcomes, safety, and satisfaction. Their engagement and well-being are intrinsically linked to the overall effectiveness and performance of the health service.

The Quality Statement for Maternity and Neonatal Services[2], captures three questions in relation to workforce, which need to be considered against the findings in this workstream:

- Is the national strategic perinatal workforce plan implemented, ensuring appropriate multiprofessional staffing across services?
- Is there workforce information readily available and used to support optimal staffing and planning?
- Does the workforce undertake multiprofessional training and have 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?

The staff experience workstream is integral to this forward-looking assurance assessment. It illuminates how workforce pressures, culture, infrastructure, and public narratives shape the safety, quality, equity, and experience of care **right now**—and what must change to build confidence for the future. In Wales, teams are delivering compassionate care under sustained pressure: rising clinical and social complexity, high caesarean birth rates (approaching 40%), workforce shortages, and ageing estates are all affecting staff morale and service reliability. Capturing staff voices enables rapid identification of risks, prioritisation of improvement, and reinforcement of bright spots that can be scaled nationally.

This work matters because it:

- Surfaces lived experience from all staff groups to inform pragmatic, evidence-based improvements in perinatal care
- Provides a current snapshot of operational reality—where high acuity, task-driven work, and gaps in continuity can limit the personalised care staff want to provide

- Highlights unwarranted variation (e.g., specialist role deployment, equipment access) and strengthens national oversight and accountability for sustainable solutions
- Supports openness and learning by bringing moral injury, leadership disconnects, and social media-driven misinformation into view—issues that directly affect safety and retention

Approach

Evidence was gathered through a mixed methods approach: site visits, group discussions, individual interviews, professional forums, and review of local documentation. Contributions were collected from midwives, obstetric and neonatal doctors, neonatal nurses, anaesthetic doctors, anaesthetic staff, allied health professionals, support staff, managers, students, and service user representatives, with the panel lead spending 15 days across all Health Boards delivering maternity and neonatal care in Wales, ensuring day, weekend and night shift staff had an opportunity to contribute.

A structured framework was utilised which enabled the consistent exploration of workforce pressures, clinical acuity, leadership, infrastructure, service organisation and the influence of wider societal factors such as social media. Themes were identified independently, cross-validated across sites, and mapped to national service standards and known system pressures. This approach ensured the findings reflect genuine cross-system pattern as opposed to isolated issues. Detailed methods are described in Section 2.

Key Staff Experience Themes

The staff experience evidence revealed seven interrelated national themes that consistently shaped how maternity and neonatal services are experienced by those delivering care across Wales. These themes reflect the realities of working in increasingly complex, high acuity environments while striving to provide safe, compassionate, and personalised care. Importantly, they also highlight areas of resilience, innovation, and commitment that offer a strong foundation on which improvement can be built. Direct quotes from staff are contained within this section and are representative of the many staff voices we heard, these quotes are intended to convey the strength of feeling behind these emergent themes.

Together, these themes provide insight into the conditions under which care is currently delivered, the barriers staff face in sustaining quality and safety, and the opportunities for action to strengthen workforce wellbeing, service sustainability, and woman, parent and family experience.

Workforce Capacity, Acuity and Postnatal Pressure

What staff told us

Staff across all Health Boards described sustained pressure arising from workforce shortages combined with escalating clinical complexity. This was felt most acutely in obstetric-led and postnatal areas, where rising caesarean birth rates have significantly increased workload and acuity. These pressures often resulted in care becoming task-focused, limiting time for relational, personalised support.

> "Even when we are stretched really thinly, I still believe we provide good care, but this is becoming less often as we are short staffed more and more."
>
> "Time now is transactional not relational—it puts a lot of pressure on to get things done."

Bright spots

Staff repeatedly described strong peer support, professionalism, resilience, and an enduring commitment to quality care. Teams across sites noted collective problem-solving and a shared determination to "do the right thing" for women, parents, families and babies, even in challenging conditions.

Improvement opportunities

Staff frequently highlighted perceived misalignment between current staffing models with modern complexity of need. Birthrate Plus®, the established midwifery workforce modelling tool, was described by many as underestimating current postnatal workload. Staff expressed support for developing or adopting a validated postnatal acuity tool, viewing this to inform staffing decisions, support staff wellbeing, and protect time for care-focused practice.

Out-of-Guidance Birth Requests and the Influence of social media

What staff told us

Staff described supporting care requests that fall outside clinical guidance as emotionally challenging and professionally exposing. Staff described morale injury and professional vulnerability, particularly where expectations were influenced by misinformation accessed through social media. These situations were most difficult in settings where continuity of care was limited, leading to adversarial conversations and heightened anxiety.

> "We are doing our best, but they (women) are coming in with expectations that are too high. We need to be honest from the beginning e.g. prevalence of birth out of guidance we are almost too scared to tell them (women)".
>
> "Most colleagues and managers and leaders focus on what's best for women and their families. One area where it is particularly difficult though is in relation to high-risk home births where midwives don't feel supported when the woman is insisting on having an out of guidance birth".
>
> "Out of guidance… we bend the realms of what is safe… The most challenging… that midwife has never returned to practice."
>
> "Social media is creating a sense of fear and as a profession we have lost respect and trust".

Bright Spots

Staff consistently described a commitment to shared decision-making and supporting women with compassion and respect. Where continuity models or established multidisciplinary relationships existed, teams reported more constructive conversations and improved trust.

Improvement Opportunities

Across sites, staff highlighted the need for clearer, consistent frameworks for individualised care, improved continuity models, and a coordinated national communications strategy. Staff highlighted the potential value of accessible, evidence based digital content such as short videos and myth busting resources to counter misinformation, to support them, and to rebuild trust at a population level. Staff felt they were unable to correct the misrepresentation in the media and wanted to see consistent and accurate information for the public from Health Boards and government.

Early Career Workforce (Streamlining) and Skill Mix

What staff told us

Streamlining was introduced by the Welsh Government to ensure all newly qualified midwives and nurses had a guaranteed job with a minimum of 22.5 hours. It was described as a positive commitment to workforce entry, while staff also reported unintended consequences. Part-time starts, frequent rotations, and large cohort intakes were said to slow skill consolidation and increase supervisory demands on experienced staff. Coordinators and senior midwives described intensified pressure where skill mix gaps were more apparent in high acuity areas.

> "As a coordinator I felt I was constantly having to reassess where staff needed to be deployed".
>
> "If you are newly qualified it is going to be hell".

Bright Spots

Staff expressed strong pride in supporting newly qualified colleagues and valued their role in nurturing future practitioners. Many described a deeply held sense of responsibility for maintaining standards and protecting patient safety.

Improvement Opportunities

Many staff suggested that a preceptorship period focussed more on consolidation of physiological and biomechanics of labour, reduced early rotation, and greater access to full-time posts where possible, would support skill consolidation. Midwives also highlighted the importance of adequate exposure to physiological birth during training to sustain capability for low-risk care.

Specialist Roles

What staff told us

Specialist roles were described as a valuable and important component of maternity and neonatal services, particularly in areas such as bereavement care, diabetes, safeguarding, and infant feeding. Staff reported that these roles enabled women, parents and families to receive time, continuity, and focused expertise that was increasingly difficult to provide within core staffing models.

However, across multiple Health Boards, staff reported considerable variation in how specialist roles were deployed, funded, and expected to function. Many of the neonatal specialist roles were also split with standard nursing duties, often without any protected time allocated to fulfil the specialist component of the post. In several group discussions, staff highlighted differences in role scope, access, and clinical expectations depending on locality. Some staff felt strongly that this variation contributed to inequity in service provision for women, parents and families across Wales.

> "We really rely on the infant feeding support team, but the money is fixed term and when people leave, they're not replaced".
>
> "Infant feeding teams are essential, but hours are being reduced even though breastfeeding is meant to be a priority".
>
> "There has been an investment by the senior leadership team in specialist roles but there is no money to secure them in the long term".

In some discussions, staff also raised concerns about maintenance of clinical practice within specialist roles. Some staff felt that where clear expectations to remain clinically active were absent, this could lead to deskilling over time and impact on how these roles were perceived by colleagues.

> "There's no expectation for some specialist roles to work clinically anymore — and over time that takes away their credibility".
>
> "Midwives are trained to look after women holistically. When you lose that clinical touch, something about the role changes".

Bright Spots

Staff consistently described specialist roles as most effective where they were visible, embedded within clinical teams, and responsive to local population need. In these contexts, specialist posts were reported to enhance staff confidence and capability, while also improving women's and parents experience of care, particularly along complex, sensitive, or high-need pathways.

Improvement Opportunities

In several group discussions, staff suggested that greater consistency in how specialist roles are defined and deployed across Wales would help reduce the variation they currently experience, particularly where local population needs differ. Many staff reported that clearer, more transparent expectations for how these roles should operate, including the extent to which postholders remain clinically active would help maintain credibility and ensure specialist skills continue to complement core practice.

Some staff felt strongly that long-term, substantive funding for specialist posts would improve stability and continuity, noting that reliance on fixed-term arrangements created uncertainty for teams and risked the loss of progress when experienced specialists moved on.

Transitional Care

What staff told us

Transitional care was consistently described by staff as one of the most positive developments across maternity and neonatal services with multidisciplinary care enabling women and babies to stay together. In multidisciplinary discussions, many staff reported that transitional care significantly improved experiences for women, parents and families by enabling mothers and babies to remain together.

Staff described this model as emotionally supportive for families and professionally aligned with their values around compassionate, family-centred care.

> "Transitional care has completely changed the experience for mums — they don't feel like they've lost their baby to another service."
>
> "Keeping mothers and babies together makes such a difference — it's what we should always be aiming for."

Alongside these positive experiences, some staff expressed concern about the funding security and long-term sustainability of neonatal roles supporting transitional care. In several discussions, staff described uncertainty regarding continuation of posts and reported concern about the impact this could have on a model of care they viewed as highly beneficial.

> "The benefits are obvious — but the concern is always whether the funding will still be there next year."
>
> "If those neonatal posts disappear, transitional care just won't work in the same way."

Bright spots

Many staff reported that integrated neonatal roles strengthened continuity and communication between maternity and neonatal teams, contributing to a more joined-up experience for families.

Staff also expressed pride in being able to provide care that keeps mothers and babies together, which was described as both professionally rewarding and aligned with core values of compassionate, family-centred care.

Improvement Opportunities

In several discussions, concerns were raised that where staffing capacity or resources were limited or insecure, transitional care models were more fragile, placing additional pressure on teams and increasing the risk of inconsistency in how care could be delivered.

Equipment, Digital Infrastructure and Estates

What staff told us

Staff across maternity and neonatal services frequently reported difficulty accessing essential equipment at the point of need, describing inefficiencies and frustration that affected flow and experience. Many staff highlighted challenges with IT interoperability and outdated systems, which were said to add to workload through duplication and delays. Estate constraints, particularly limited space were reported to restrict partner presence and elements of family-centred care.

> "It feels a little battle with the lack of equipment… We don't have enough beds."
>
> "We need an upgrade to our labour ward—the rooms are tiny and the theatres are small."

Bright Spots

Staff described adaptability and ingenuity in working around environmental constraints, often borrowing equipment or redesigning workflows to maintain safety and flow.

Improvement opportunities

Across sites, staff pointed to targeted investment in equipment availability, digital infrastructure, and estates modernisation as changes that would significantly improve efficiency, staff morale, and the experience of women, parents and families. Staff also noted an all-Wales approach could help reduce variation and futureproof services.

Leadership, Culture and Visibility

What staff told us

Clinically based leaders were widely viewed as credible, supportive, and grounded in frontline realities. In contrast, staff described disconnects with senior strategic leadership, particularly where changes were perceived to occur without adequate engagement or codesign.

> "Senior staff should be expected to work clinically to remain credible."
>
> "They made recommendations, but nothing has changed. What is going to be different with this one?"

Bright Spots

Consultant midwives and clinical leaders were consistently identified as trusted advocates for evidence-based practice and quality improvement. In areas where leadership was visible and engaged, many staff reported higher morale and psychological safety.

Improvement opportunities

Staff frequently highlighted the importance of leadership visibility, coproduction, and alignment between strategic and clinical leadership. These elements were described as helping rebuild trust, support retention, and foster a culture of learning rather than reactivity.

Summary

Across all seven themes, staff described a perinatal workforce that is committed, resilient, and values women, baby- and family-centred care, yet constrained by structural, cultural, and environmental pressures. The consistency of these accounts across Wales provides a clear picture of current conditions, the pressures affecting quality and safety and the areas staff believe are helping services to cope. Staff also identified patterns of variation and practical opportunities, which if addressed, were described as likely to support workforce wellbeing, service sustainability and the lived experience of women and families.

Section 6: Healthcare organisational leadership, culture and governance

Approach

Gaining insight into organisational leadership, culture, and governance at Health Board and at a national level was conducted in two phases. The aim was to generate a comprehensive and triangulated understanding of organisational culture, governance, leadership, and service quality at Health Board and national levels.

The first phase assessed organisational maturity across all NHS Wales seven Health Boards delivering maternity and neonatal services. The approach combined structured self-assessment, formal validation processes and targeted evidence review, including triangulation with other workstreams. Semi-structured interviews were then conducted with board members and separately with senior clinical and operational leaders. These were conducted towards the end of the review process to allow sufficient triangulation of evidence. All Health Boards engaged in the process in an open manner, which enabled meaningful and broad discussion.

The second phase included a questionnaire to national organisations and multiple conversations with maternity and neonatal leaders and related organisations.

Triangulating these findings with evidence from across all the workstreams highlighted and informed areas that required further scrutiny or evidence of impact.

A full explanation of the methods used is provided in Section 2.

Structured self-assessment

The self-assessment tool assessed organisational maturity across eight domains aligned to the Welsh Government commission and findings are presented here in each of these Domains. Aggregated scores for each Domain are shown in the charts in Appendix D.

Domain 1 - Organisational Culture and Values

Statements Scored in Domain 1:

1.1a Staff feel psychologically safe and confident to raise concerns without fear of blame.

1.1b The Speaking up Safely framework is embedded with a clear escalation system operating from ward to board.

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.

1.3 The Board and service leadership teams value and include diverse perspectives in developing continuous improvement plans.

1.4 Leadership communicates organisational values consistently communicated through two-way channels, with evidence of observable impact on staff behaviour and visible Board involvement

Overview of scores

The overall aggregated score for the whole of Domain 1 for each Health Board varied from an aggregated score of 2.7 to 3.5 and an overall average score of 3.1 maturity scale for all-Wales.

The aggregated all-Wales score for each statement highlighted variation in scores with statements 1.1b (raising concerns) and 1.3 (diverse perspectives) scoring the lowest at 2.8 maturity score and statement 1.4 (values) scoring the highest at 3.5.

Within these, two Health Boards scored themselves at a maturity of 2 for 1.1b (Speaking Up Safely framework). Conversely two Health Boards scored themselves as a maturity of 4 (being the highest level of maturity) for statement 1.4 (values).

Perspective on accuracy of scores

Having completed the process, the self-assessment maturity scores for domain 1 were higher overall than the evidence demonstrated. There were exceptions where the Health Board scores in 1.1b (raising concerns) and 1.3 (diverse perspectives) were more closely aligned to the evidence and experience of staff. However, some of the individual Health Board scores in statement 1.4 (values) were overstated, with scores of 3 and 4. The scores in these cases did not show sufficient insight considering the evidence and triangulation of staff experience in some Health Boards.

Key findings

At an all-Wales level the prioritisation of perinatal services over the last two years has made a tangible positive shift in the culture of board ownership with clear evidence that provider boards have increasingly focused on maternity and neonatal services. This recognition and culture of ownership was strengthened to recognise the importance of perinatal services in overall quality and safety. This has resulted in increased recognition that neonatal services are a fundamental part of the multidisciplinary team together with maternity services. This perinatal focus was noted to be a positive cultural shift that was stated to largely be prompted by the Maternity and Neonatal Safety Support programme[1] programme of work which is now in the implementation stage.

Some aspects of this renewed focus on perinatal services are continuing to strengthen in some Health Boards. This includes key areas such as aligned perinatal leadership structures and governance to ensure it is sufficiently embedded in a more systemic and enabling manner, to allow teams to thrive and deliver high quality care.

There was some suggestion from Health Boards, triangulated by written evidence, that there was a risk emerging that this focus was starting to diminish in some areas where they feel the key actions have already been taken. Another associated aspect raised by some clinicians and leaders, was the competing demands on Health Boards and the fact that perinatal services are seen as a comparatively 'smaller' overall service within the overall remit of Health Boards' provision. Culturally, this is causing some concern regarding the sustainability of sufficient focus on perinatal services by boards and the corresponding impact on the likelihood of being able to address some risks.

Examples of the risk that pace and progress will diminish include where there had been a culture of short-term funding to deliver fundamental pieces of work, particularly at implementation stage of previous reviews and programmes of work. This resulted in more short- and medium-term aims being focussed upon to align with these short-term contracts. It is essential that sufficient long-term commitment and robust oversight is given to national implementation work and where there is an extensive number of recommendations they are systematically considered for alignment and prioritisation, and not dependent on short term roles.

Another example is the issue of suitably located theatre capacity for maternity services and being able to address the wider estates challenges within perinatal services. Examples were given in relation to the balance of risk between delivery of general elective theatre capacity and the need for theatre capacity in maternity services. Senior clinical teams raised the potential of not being heard in a meaningful and sustained manner, if the risks associated with perinatal services are not sufficiently prioritised within the wider demands of the Health Board.

Senior leaders felt there was a positive culture where staff felt safe to speak up, leaders were visible, there was a culture of empowerment, and staff had positive working relationships across teams. This included examples of maternity services Schwartz rounds[32] and cultural questionnaires in some Health Boards showing a positive impact.

However, the triangulation of data including staff feedback during the review, some poor results in General Medical Council (GMC) and Royal College of Obstetricians and Gynaecologist (RCOG) surveys, and feedback from students and resident doctors demonstrated there was more work needing to be done to create a culture when staff felt safe to speak up in a consistent manner. Reporting and governance mechanisms to assess culture were not sufficiently robust in some Health Boards as the governance mechanisms did not routinely capture the breadth of intelligence needed. This includes staff feedback, high sickness levels associated with mental health, and reports of teams having insufficient time for development or innovation. Furthermore, feedback through other workstreams suggests visibility of leaders, and feeling safe to speak up, needed focused work in some Health Boards.

At a local team level there was evidence across workstreams that teamwork with immediate colleagues was highly valued and consistently strong, and there were examples where this was underpinned by a culture of collectively striving to ensure women and families were at the heart of their care. Where there were isolated pockets of team dysfunction, this was known in most cases with focused work underway to address it. However, there were examples of a disrespectful and undermining culture within and between teams being reported in our staff engagement workstream, that were not known by senior leaders and therefore not being sufficiently addressed. A more systematic approach to reviewing qualitative and quantitative intelligence related to culture and staff well-being was needed in some Health Boards. When this holistic strategic approach was discussed with senior leaders, there was no consistent view or understanding of any national drivers or associated all-Wales People Plan to underpin the Health Boards' work in this area in a more aligned and guided manner.

A culture of continuous improvement across perinatal services was not reported to be systemically embedded within Health Boards to enable teams to thrive, learn and innovate.

When discussing the input of the perinatal teams' clinical voices into the development of national frameworks and the overarching oversight frameworks, there was clear variation in whether teams within the multidisciplinary team felt there was a culture of being valued and heard. There was strong evidence from senior clinicians that some clinical teams were perceived to have a stronger voice than others. Furthermore, where they felt they had a clear voice in the all-Wales national governance structures, they did not always feel they had an impact. This variation resulted in the collective perinatal voice that was being strengthened within Health Boards, not being replicated sufficiently at an all-Wales level. The gaps in some specialties' voices being heard effectively and the extended time it took for decisions to be made, resulted in less confidence that things will progress at the necessary pace to have impact on outcomes. This wasn't underpinned by a lack of engagement from clinical teams in most cases; it was due to governance frameworks not enabling a culture of the perinatal voice being heard systemically. Staffing pressures within Health Boards, such as obstetric staffing, were one underpinning reason.

It was evident that the UK-wide national public perception of maternity services was impacting on teams' morale. This was described as feeling "demoralising", with some reporting they felt less proud or safely able to say they were a midwife when out socially, in contrast to previously being proud to say they were a midwife in public.

There were consequences and concerns regarding sustainability of the clinical professions and attracting a sufficient future workforce to provide safe perinatal services longer term. This was recognised as needing more alignment and strategic planning across all-Wales partner organisations.

Constructively, we did not experience any defensiveness from boards or wider leadership teams during the review. They talked openly and in a meaningful manner during the semi-structured interviews about their opportunities, risks and the need to address them either locally or nationally. There was a very clear commitment to work effectively across Health Boards, recognising the collective need to collaborate and learn across Wales to drive the necessary changes, and at the right pace. Whilst there was a clear collective aspiration to drive further improvement across perinatal services, there was simultaneously a clear culture of apparent inertia and lack of pace in key decision making. This inertia was underpinned by examples where accountability was suggested to be elsewhere. This included implementation of key decisions which were tied to specific areas of safety, such as the implementation of a national triage line, neonatal cot configuration and the decision to delay other key work such as workforce planning, until confirmed. In the case of the Joint Commissioning Committee (JCC) decisions on the phase 2 neonatal transformation programme (neonatal cot configuration work) the decision makers are in effect the commissioner and the provider, as all Health Board's Chief Executives sit on the JCC. Therefore, the rationale for delay could be seen as a circular argument.

The short-term contracts of many key roles associated with implementation of key pieces of work across perinatal services, coupled with instability of roles in teams across NHS Performance and Improvement (NHS P&I) at a national level, have resulted in a culture of instability and lack of longer-term planned sustainable change. The consequence is some ambitions are more aligned to what can be achieved in a short-term contract, as opposed to empowering teams to embrace the wider need for implementation with ambition and confidence of delivery. This is seen as a concern by many stakeholders. To compound this, much of the implementation of key priorities across Wales, particularly from national reviews, requires a large element of self-assessed assurance and compliance, without sufficient scrutiny, due to a lack of robust oversight frameworks.

Another unique aspect of the culture across Wales is underpinned by the fact that the workforce pool across Wales is smaller than a larger nation and while presenting many positives, can create the potential for closed cultures where fresh eyes were not routine or embedded in governance. There were some examples of 'teams not knowing what they didn't know' as a culture of gaining external views and proactive benchmarking was not consistently present across teams. This was compounded by a historic lack of focus on perinatal services at Health Boards and national level to support and enable teams. This gap in accountability frameworks had in some cases not been sufficiently robust to highlight and escalate concerns until more recently. This was particularly evident when a new leader commenced in role, such as a Director of Midwifery or Medical Clinical Director in some Health Boards, who recognised the provision of care as not meeting the required quality standards or outcomes. With the strengthened oversight and an associated culture shift by these new leaders, previously unrecognised areas of concern were improved. This is, in part, tied to the shift in culture and priority both nationally and by Health Boards, where more longstanding clinical and operational teams have felt more supported to make the necessary changes than they had previously, with clear focused pieces of work underway to address any pockets of poor culture.

Domain 2. Clinical and Professional Leadership

Statements Scored Domain 2:

2.1a Clinical leaders are identifiable at all levels, with named consultant, midwifery and neonatal nursing leads accountable for safety and quality.

2.1b Clinical leaders are visible in frontline areas.

2.2 Leadership actively promotes safe, high-quality care and staff wellbeing, with defined escalation routes from ward to board.

2.3a Multidisciplinary leadership teams collaborate regularly, including consultant-led ward rounds, with clear processes, documented decision-making and shared accountability.

2.3b Multidisciplinary perinatal leadership team meetings take place with appropriate professional representation to plan care for women with complex needs.

2.4 There is a formal leadership development and succession planning, inclusive of diverse future leaders supported by resources for leadership development.

Overview of scores

Domain 2 was the highest scoring domain overall. The overall aggregated score for each Health Board varied from an aggregated score of 2.8 to 3.8 and an overall average score of 3.3 for all-Wales.

The all-Wales score for each statement highlighted variation in scores of 2.9 for statement 2.4 (leadership development) to the rest of the scores between 3.2 to 3.8 overall for the rest of the statements.

Within these, only statements 2.3b (multidisciplinary perinatal leadership) and 2.4 (leadership development) were assigned overall scores of 2 by some Health Boards, but the rest of the scores for the remaining statements across the whole of Domain 2 were between 3 and 4 suggesting the highest levels of maturity in scores. However, even within the statements 2.3b (multidisciplinary perinatal leadership) where some assigned scores of within the range or 2, there were three Health Boards scoring themselves a 4.

Perspective on accuracy of scores

Having completed the process of evidence review, triangulation and semi-structured interviews the self-assessment maturity scores for Domain 2 were higher overall than the evidence demonstrated. Whilst there were some individual examples and positive work underway aligned to the higher scores, the breadth of evidence and triangulation with other workstreams suggested overall scores were higher than the evidence demonstrated.

Key findings

There was mixed evidence regarding clinical leadership when evidence was triangulated. There were some extremely positive examples of clinical leaders across perinatal services being clearly identified and working collaboratively with clear collective visions and priorities. However, there were also clear examples when the evidence was triangulated with staff, students and resident doctors' feedback, highlighting that whilst the key leaders were identified they were deemed inaccessible, too busy to approach and in some cases not creating an environment where it was safe to speak up without consequence.

The evolution of the perinatal leaders working collaboratively across services was in transition, from being quite separate structurally in some Health Boards to teams that are more clearly aligned and working effectively across the perinatal multidisciplinary team. It was widely acknowledged there was more work to do in these areas to run a truly aligned perinatal service across Wales.

At a national level the structures to ensure clarity of clinical leadership across all perinatal professionals was not consistently clear to clinicians at Health Board level, with gaps in being able to identify the clinical leadership model. Even where the clinical leadership model nationally was more evident, such as neonatal and midwifery, the timeliness and breadth of impact from these structures was not seen to be significant.

Because of the Maternity and Neonatal Safety Support Programme (MatNeo SSP)[1] there is more recent tangible change in the recruitment of a Director of Midwifery in all Health Boards, apart from one which had plans to do so. However, one key risk that was evident was the potential for too much assurance to be placed on that one key role to allow some executive teams to 'step back' and take assurance. Given the scale of work to be done across perinatal services both strategically and operationally, the focus at all clinical leadership levels needs to be maintained. Furthermore, the potential lack of clarity of role for Heads of Midwifery (HoM) compared to Directors of Midwifery (DoM) and Consultant Midwifes was, at times, resulting in the HoM feeling disempowered, despite there being a being a wealth of talent at this level that requires a different skill to the role of a DoM. As perinatal teams evolve, this clarity in purpose and alignment of roles in a collaborative and supportive manner will be essential for the collective success given the scale of work. We did see some examples of excellence in leadership across teams and genuine value of diversity of thinking and shared accountability.

We also saw impactful examples of teams recognising the journey they themselves have been on, where they had collectively needed to improve. They were able to demonstrate insightful learning from what had driven the change from a team that was perceived as defensive, not learning and working in an environment that was culturally safe, to one that was more open, collaborative and able to drive a quality service more effectively and working with women and their families. Whilst there were aspects such as short staffing and lack of key skills being rationales for that former poor culture, overwhelmingly one of the key drivers for success in the necessary transition was the fact they now had board members and board oversight that meant their key risks and voices were being heard more effectively. Increased staffing provided the capacity to learn more effectively, but board 'interest' and 'ownership' was fundamental to that change.

It was clear that in past years teams had felt unheard and isolated from boards, but more recent years have seen the necessary shift. This, however, is crucial and must be maintained and strengthened with clearer national accountability frameworks to enable escalation, oversight and support.

A key gap in perinatal services was the recognition of the importance of allied health professionals including psychology services for women and families, physiotherapy provision, pharmacy provision as some examples. Whilst some Health Boards have some provision of these in maternity and neonatal services, others did not, and this was a key gap in the clinical provision, leading to uneven experiences for women and babies across Wales.

Whilst leaders were able to clearly describe elements of staff well-being initiatives and psychology support for staff, this was not embedded in several areas and often reliant on key individuals. There were some extremely positive examples of staff support, but these were not widely known by all staff. To enable a positive culture, it is crucial for staff to feel able to thrive, and this was an area where there was inconsistency and the triangulation of data with other workstreams, such as staff feedback, sickness rates and feedback from trainee surveys demonstrates there is more work to be done.

Domain 3. Governance and Accountability Structures

Statements Scored in Domain 3:

3.1 Governance structures for perinatal care are clearly documented, understood by staff, and regularly reviewed: including integrated safeguarding systems with partner agencies.

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.

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.

3.4 Audit and review findings drive actions with monitored completion, duty of candour and meaningful parent/family involvement.

Overview of scores

The overall aggregated score for the whole of Domain 3 for each Health Board varied from an aggregated score of 2.8 to 3.5 and an overall average score of 3.2 for all-Wales.

The all-Wales score for each statement highlighted consistency as all were between 3.1– 3.3.

Within these, only statements 3.3 (data and digital systems) and 3.4 (acting) were assigned overall scores of 2 by a Health Board, but the rest of the scores for the remaining statements across the whole of Domain 3 were between 3 and 4 suggesting the highest levels of maturity in scores.

Perspective on accuracy of scores

The self-assessment maturity scores for Domain 3 were higher overall than the evidence demonstrated. Whilst there were some examples of governance having strengthened significantly, there was still much more work needed to ensure perinatal services were aligned and the triangulation of intelligence was sufficiently mature to assure boards and identify themes and risk sufficiently. There was some positive work underway that could be aligned to the higher scores, but the breadth of evidence and triangulation with other workstreams suggested overall scores were higher than the evidence demonstrated.

Key findings

Overall, governance and reporting structures had been significantly strengthened across all Health Boards in at least the last two years. However, there is still a significant amount of work needed to strengthen these further. In some Health Boards the number of layers had been streamlined and teams clearly described improvements from this. However, in others it remained a perceived barrier. Where teams felt the number of layers in the hierarchy was a barrier, this resulted in the timeliness and effectiveness of escalation and decision-making being unnecessarily delayed.

Incident investigations were reported as being conducted in accordance with the national incident reporting framework for moderate and serious incidents. However, there were inconsistencies within and between Health Boards about how much families were involved in the incident investigation process in a meaningful and proactive manner. There were some examples of positive engagement with women and families. However, in some cases, aside from Duty of Candour[33] where there is a defined requirement to notify families, the process of how women and families were involved and able to feed into the process was extremely variable and an area where significant focus is needed. This impacted on Health Boards engaging with families in a consistently open manner and their ability to capture the breadth of learning that only women and their families can share.

While some oversight and scrutiny of severe and moderate risks was present at a national level, there was no oversight mechanism in place to scrutinise whether Health Boards were appropriately grading incidents. Low harm and near miss incidents were not being sufficiently reviewed effectively for themes and trends to encourage a culture of proactive learning. It was reported that historically there had been cases where in their view incidents had not been appropriately graded, and therefore this gap in oversight and scrutiny of some incidents impacted on the systematic learning from themes or emerging trends could be being missed or delayed. Furthermore, there was not sufficient evidence that learning from themes was effectively present in Health Boards or across all-Wales. The learning culture and oversight needs strengthening at all levels with the need for a more robust and effective ambition at an all-Wales level. This needs to include learning from all partners and stakeholders, who currently only meet annually for a quality summit to share intelligence.

Learning was extracted and shared through some national forums, such as the National Strategic Clinical Network for Maternity and Neonatal Services neonatal mortality shared learning forum, but significant delays were reported in the timeliness of this process resulting in significant delays and avoidable waits for women and families. The mechanism for effectively disseminating learning across Wales for other types of reviews was unclear. Clinical leaders recognised this was an area that needed focus at all levels.

It was evident that women and families were waiting an unnecessary length of time for some reviews to be completed, when some women and families were keen to be partners in the learning journey.

A key element of learning and ensuring that closed cultures or bias are not present in governance processes and learning culture is the need to ensure an external objective perspective can be proactively sought when incidents occur. We were advised unanimously by all clinical teams that when they needed an external clinical view, this was sought by 'phoning a friend' and not a systematic mechanism to ensure the necessary support is available or encouraged through a learning culture of objectivity at a national level. This is an example of an area where there is a clear gap in a learning culture and robust governance mechanisms that had not been identified through national oversight mechanisms.

There was a lack of robust analysis of demand, capacity and associate workforce planning involving clinical teams to allow accurate metrics and board assurance mechanisms to be monitored accurately against any risk. One example was the use of Birthrate Plus® as the mandated tool to assess the staffing requirements for midwives. Whilst it appeared to be recognised that the current operating model and known increase in complexities was impacting on the acuity and provision of maternity services across all areas, this wasn't being sufficiently factored into assessing staffing requirements. Furthermore, despite known increased pressures in areas such as triage and postnatal care provision, there wasn't a clear mechanism for how the mandated tool was adapted or complemented to ensure those factors were sufficiently accounted for in the overall workforce model. In addition, unique aspects such as geography and women choosing to birth outside of guidance was not routinely part of the process for assessing staffing requirements overall.

There had been some national work in conjunction with Directors of Midwifery to add additional modules to Birthrate Plus® to account for time taken to provide for student supervision, provision of care for women choosing birth outside of guidance, and complexity of antenatal care but this was not consistently adopted in some Health Boards. Some Health Boards had not completed Birthrate Plus® recently and were due a Birthrate Plus® review imminently. This resulted in boards assuring themselves they had sufficient midwives based on an assessment that was not sufficiently broad or robust to allow them to meet the needs of women's and families. The current approach being used had the potential to not be holistic and not take account of the necessary demands and acuity within the maternity service provision. In some cases, this could result in them falsely assuring themselves staffing was sufficient.

Furthermore, assessment of staffing also didn't fully factor in the high sickness rates and maternity leave rates that were present in some Health Boards in a meaningful manner to consider the risk that may be present overall. Consequently, the overall assessment of risks associated with staffing was not sufficiently holistic in some cases. The link to staffing requirements for allied health professionals was also not sufficiently considered in the overall workforce modelling. Obstetric staffing was raised as a concern by executive and senior teams. In some heath boards there had been recent significant investment in more consultant obstetricians, with a mandate to appoint doctors with an interest and skills in obstetrics rather than gynaecology. There was awareness in others of the challenges in recruitment with significant use of locum doctors to cover substantive vacancies and gaps because of long term sickness of both consultant and resident doctors. The use of locum doctors has become normalised.

However, whilst there is in all Health Boards some recognition of the current fragility and long-term sustainability of the obstetric workforce, there was limited assurance that work was ongoing to produce a perinatal workforce plan which should provide sustainable, long-term solutions to this complex issue.

Some Health Boards did highlight areas of risk regarding recruitment, such as sonographers and more broadly paediatric radiologists. They had developed plans which would address some of the more local issues such as ultrasonography in the medium term, but Wales and UK-wide issues such as the lack of paediatric radiology require further escalation and action nationally.

The necessary breadth needed in workforce planning across the multidisciplinary team needs significant focus at an increased pace, including effectively working with universities and Health Education and Improvement Wales.

The national oversight accountability framework is unclear and difficult to map where key decisions are made and where learning is considered and communicated effectively to inform impact. This can be triangulated with evidence and feedback during the assessment more broadly. There is a quarterly Integrated Quality Planning and Delivery (IQPD) meeting led by Welsh Government, but the focus on quality and safety in perinatal services remains insufficiently robust. Senior leaders reported that it had historically been more focused on performance but had started to evolve to have more focus on quality and safety metrics in perinatal services.

The Health and Care Quality Standards (HCQS)[34] were introduced in 2023, with six quality standards and six enablers. Whilst these are not enforceable regulations, they are the primary framework against which the Duty of Quality[9] on all NHS bodies in Wales is assessed as outlined in the Health and Social Care Act 2020[35]. The national and Health Board oversight and governance frameworks should demonstrate that the Duty of Quality is measured effectively. The evidence from Health Boards and senior leaders did not demonstrate the HCQS were being systematically implemented across governance or planning frameworks in a meaningful and measurable way across perinatal services to demonstrate compliance with the statutory Duty of Quality. The IQPD meetings were one of the mechanisms to provide oversight, but evidence confirmed these were not sufficiently robust in benchmarking and assessing quality of perinatal services, although it was recognised this process was starting to strengthen.

Even where performance was being monitored more recently in Health Boards because of the Maternity and Neonatal Safety Support Programme[1], key performance safety-related indictors such as triage metrics have never been reported there to date despite triage being identified as an area of risk nationally. Triage has recently been agreed as a metric that does need to be presented at IQPD meetings going forward. In some Health Boards, triage areas were an area of increased risk where delays and staffing were reported to be an area of more challenge to clinical teams. This was triangulated with other workstreams as requiring further risk mitigation locally and nationally. Part of the risk reported by clinical teams was associated with triage areas also being areas where routine scheduled care was provided, and some data suggested that in some cases over 40% of the care provided in a triage area was scheduled care or care that should have been provided elsewhere. At times this presented a poor experience for women and families due to the delay, but also a risk that triage care wasn't being sufficiently prioritised in some cases. Further analysis to understand the risk was needed in some Health Boards.

Birth 'outside of guidance' was an area that all Health Boards recognized needed further focus. They welcomed a national approach to managing scenarios where women chose to birth 'outside of guidance', to ensure they were sufficiently supported, and were appropriately informed, with robust mechanisms in place for informed consent. There was in most cases a multidisciplinary team approach to supporting women and teams, however in some cases there needed to be more work to ensure an obstetrician was able to contribute effectively to discussions with women. Digital solutions were being considered. Some Health Boards could demonstrate excellent senior support for staff who undertook the care of women in this situation. Work was underway, led by the consultant midwife group in Wales, to produce national guidance which will then need rapid implementation.

Health Boards have worked collectively and individually with the Welsh Ambulance Services Trust in relation to developing some pathways and training programmes.

Domain 4. Quality of Care and Service User Outcomes

Statements Scored in Domain 4:

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.

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.

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.

4.4 Staff are competent and confident to carry out their relevant roles and to work effectively across a multidisciplinary team.

4.5 Improvement projects show measurable, sustained results aligned with national programmes, demonstrate women, parent and family impact and efficient/sustainable use of resources.

Overview of scores

The overall aggregated score for the whole of Domain 4 for each Health Board varied from an aggregated score of 2.6 to 3.3 and an overall average score of 3.1 for all-Wales.

The all-Wales score for each statement highlighted consistency as they were between 3 – 3.3.

Within these, only statements 4.4 (multidisciplinary team confidence and competence) and 4.5 (improvement activities) were assigned overall scores of 2 by some Health Boards, but the rest of the scores for the remaining statements across the whole of Domain 4 were between 3 and 4 suggesting the highest levels of maturity in scores. Statement 4.1 (outcome measurement) was the only statement where a Health Board had scored themselves a 4.

Perspective on accuracy of scores

The self-assessment maturity scores for Domain 4 were mixed overall. Some scores were deemed to be more accurately aligned to the evidence and triangulation than the evidence demonstrated. This included 4.2 and 4.4, where boards recognised the need to do further work and had plans and mitigations. However, the overall score for 4.1 (outcome measurement) had a maturity score at the highest level in some Health Boards and was not in line with the evidence provided.

Key findings

Data availability was variable across Health Boards and their ability to benchmark on outcomes was an area where all Health Boards felt there needed to be more national focus, support and oversight. All Health Boards were able to describe a journey of improvement in this area. However, a significant amount of work remained to be done in relation to quality, safety and performance metrics being reported and used effectively across clinical teams to inform decisions and improve care for women and families. Until recently, clear metrics on areas of risk such as triage were not robust, but they have been a chosen workstream during the implementation of MatNeo SSP[1] programme of work. A national Beacon Dashboard was in progress of being compiled at the time of the review but has not yet been used or referenced by clinical teams.

Outcome measures were collected across a range of areas (as seen in Section 3), but there wasn't a consistent culture of taking a strategic overview of several metrics to provide a more holistic picture of risks and outcomes across perinatal services. Furthermore, it wasn't evident how those outcomes were used to inform national and local decisions or priorities in the planning cycle.

Teams were unable to describe an aligned long term digital strategy to enable improvements across Wales. They described more specific streams of work to include a Beacon dashboard and implementation of BadgerNet® Maternity individual digital health records across Wales. However, even with such a nationally driven initiative to implement BadgerNet® Maternity, there remained confusion over which modules were being used to drive the necessary change in digital alignment. There was a concern that Health Boards were, by necessity, implementing the system in isolation rather than taking a whole-Wales approach. There were examples where a unique approach to local implementation on areas such as venous thromboembolism (VTE) could result in the alignment intended not being as effective post implementation. Leaders felt a national approach to these areas (VTE and others) needed to be a key part of the work to achieve the overall impact.

There were areas where effective care pathways were compromised by lack of commissioned services for all-Wales, including safety critical areas such as a placenta accreta spectrum pathway. We noted examples of care in these scenarios being reliant on obstetric staff knowing a colleague in another Health Board in Wales or a provider in England and agreeing care needs between them based on relationships. There was a recognition this was a known risk and not sufficiently safe but addressing this would need a collective approach commissioned by all providers given the rare nature of these safety critical pathways. It was evident that clinical teams were unclear how to escalate such national priorities to effect sufficient change when the issue was broader than their own Health Board's remit, needing an all-Wales solution.

Staff competency and skill mix was a notable concern for quality and outcomes in several areas. One example consistently referred to be the commitment to streamlining; this approach to offering posts to all new graduates was recognised as a positive initiative. However, it was viewed that there was also an unintended consequence that it had resulted in a higher proportion of midwives and neonatal nurses at band 5, diluting the overall skill mix and impacting on newly qualified colleagues getting necessary support. Neonatal teams didn't report this as impacting so broadly, with plans to ensure band 5 nurses were on a clear trajectory to gain their competencies in many cases. In maternity services, it was stated across workstreams as a clear and real risk that senior leaders faced regularly to ensure there were sufficient midwives with the appropriate skill mix across all clinical areas.

The other area where maintaining competency needs further consideration is where the unique geography and structure of provision across Wales requires units with low birth rates to be maintained. However, maintaining competency in midwifery and obstetric staffing in these areas is an area of potential risk. This included smaller hospitals and freestanding midwifery units. This did not have a sufficient oversight in all Health Boards, although there were plans being put in place to consider further mitigation of potential risk in some.

Whilst the alignment of maternity and neonatal leaders was a more recent and current shift, there were some positive examples of initiatives where teams were undertaking collective leadership training to underpin effective multidisciplinary team working across perinatal services. One example included a Health Board seeking the expertise of international expert Professor Michael West to inform their perinatal leadership programme, but this was awaiting approval prior to implementation. Another key area of focus, consistently reported positively, was the all-Wales PROMPT training programme.

Domain 5. Staff Experience, Voice, and Engagement

Statements Scored in Domain 5:

5.1 Staff feedback is actively sought with actions and impacts communicated back.

5.2 Staff wellbeing is monitored and supported with psychological safety embedded and timely access to support through accessible services and proactive initiatives.

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.

5.4 Decision-making and improvement project activities demonstrably involve diverse staff groups, from a wide range of professional backgrounds, ethnicities and lived experience; to reflect multiple perspectives, reduce blind spots and foster an inclusive culture.

5.5 The working environment enables all staff groups to thrive and innovate to drive improvements in a culture of curiosity

Overview of scores

The overall aggregated score for the whole of Domain 5 for each Health Board varied from an aggregated score of 2.6 to 3.4, with an overall average score of 3.

The all-Wales score for each statement demonstrated variation as scores were between 2.7 – 3.3.

Within these, statement 5.1 (staff feedback) was scored the lowest at 2.7 and statement 5.2 (staff wellbeing) scored the highest in the domain with a score of 3.3. All the statements in domain 5 had some Health Boards scoring a 2 and some scoring a 4, except for statement 5.1 (staff feedback) where all scores fell to between 2 and 3.

Perspective on accuracy of scores

The self-assessment maturity scores for a proportion of Domain 5 were in line with the evidence in most cases, where Health Boards recognised they had more to do in these areas to strengthen their maturity scores from between 2 and 3. There were some higher maturity scores given, of 3 and above, including scores of 4. These were not in line with the evidence seen and heard, as there remains work to do in all areas of this domain to sufficiently embed and strengthen staff experience, voice and engagement.

Key findings

This domain overall is an area that requires significant focus from Health Boards. Some of the content relating to this domain is covered in Domain 1 and Domain 2 due to the overlap with culture and clinical leadership, so should be read in conjunction with the key findings below.

Whilst there is a clear positive shift in executive focus on perinatal services, and some positive examples where staff feel able to speak up and feel supported by their peers, there is work to be done in several areas. An example is Caring for You, an initiative from the Royal College of Midwives now being adopted in Health Boards with the aim of improving members health, safety and wellbeing at work. As described in Domain 1, there are areas for further cultural work relating to speaking up safely and belief that doing so will result in a change, including feeding back to those who speak up.

There was evidence of staff well-being services being available to staff across the Health Boards, for example if they need to access psychology services. However, there remains a high level of sickness and impact on mental health as an area needing increased focus. When discussing how Health Boards strategically prioritised these areas against the national priorities relating to staff well-being, there was not a clear understanding of what the direction of people priorities from an all-Wales perspective were.

The evidence relating to opportunities for learning, and protected time for this, was varied. There were some positive rates of compliance with some aspects of mandatory training, however, there was less evidence of ongoing staff development including leadership development, particularly due to staffing pressures. Equally, as described above, creating spaces for teams to proactively innovate was not embedded and leaders recognised training in improvement methodology to drive learning was not systematic.

In addition, a culture of improvement and the development of teams was not present for senior leaders collaborating across the networks and nationally. There was a lack of clearly defined direction in relation to an NHS Wales plan focussed on people to outline expectations and guidance.

Domain 6. Women, Parent, Family and Community Involvement

Statements Scored in Domain 6:

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.

6.2 Representative feedback is used to inform priorities, with consistent Patient Reported Experience measures (PREMs), real-time engagement, and triangulation with outcomes.

6.3 Service information/changes are communicated in accessible formats, in the language and method of choice, with Welsh actively offered.

6.4 Active partnerships with community and advocacy organisations are influencing seamless service delivery across primary, secondary and tertiary care, including regional services.

6.5 When things have gone wrong, 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.

Overview of scores

The overall aggregated score for the whole of Domain 6 for each Health Board varied from an aggregated score of 2.5 to 3.4 and an overall average score of 2.8 for all-Wales.

The all-Wales score for each statement highlighted consistency as they were between 2.7 – 2.9.

Within these, statements 6.1 (stakeholder engagement) and 6.2 (prioritisation) were the only statements where a Health Board had a score of 4. The great majority of scores across the statements from Health Boards fell between 2 – 3.

Perspective on accuracy of scores

The self-assessment maturity scores for Domain 6 were in line with the evidence. Overall health board were doing some positive examples of working with women, families and communities, but they recognised there was a significant amount more they could do to engage and involve more but also consider the impact on care and outcomes.

Key findings

Overall, there were some positive individual examples of engaging with women, parent, families and communities across the Health Boards. These included examples of engaging with vulnerable and diverse groups and engaging with doulas proactively to support women choosing to birth outside of guidance.

However, as described in Domain 3, there needed to be systematic improvements in the consistency and quality of involving women and families in incident investigation to ensure they had the opportunity to feel heard and sufficiently influence and be part of the wider learning journey.

While there were limited examples of good practice, the involvement of women and families in strategy, planning services and understanding their perspectives in a more routine and systemic manner was not routinely present. Health Boards were doing more to engage with their communities more broadly, but it was less clear how women and families were proactively involved in influencing and sharing their perspectives to reduce inequalities and inform the future provision of care. Co-production was an area where all Health Boards wanted and recognised that they needed to do further work, to ensure they engaged with women and families as equal partners to inform care provision, prevention and reduce inequalities. The new Perinatal Engagement Framework[36] requires this to be done systematically in each Health Board area.

Domain 7. Equity, Diversity, and Inclusion

Statements Scored in Domain 7:

7.1 Targeted, resourced actions to address health inequalities for under-represented groups are delivered and evaluated for impact.

7.2 Staff receive cultural safety competence and inclusion training, with uptake and impact monitored across professional groups.

7.3 Women, parent and family outcome data is routinely analysed by protected characteristics, with consistent monitoring and quality assurance of data accuracy/completeness.

7.4 Documented equity, diversity and inclusion initiatives demonstrate measurable improvements in access and outcomes.

Overview of scores

The overall aggregated score for the whole of Domain 7 for each Health Board varied from an aggregated score of 2 to 3.1 and an overall average score of 2.5 for all-Wales. This is the lowest scored domain from the self-assessment.

The all-Wales score for each statement highlighted consistency as they were between 2.3– 2.7.

Within these, no statements received a score of 4 from any Health Board. The great majority of scores across the statements fell between 2–3. Statement 7.4 (equity, diversity and inclusion initiatives) was the exception with one Health Board scoring higher than a 3 and some Health Boards scoring below 2.

Perspective on accuracy of scores

The self-assessment maturity scores for Domain 7 were more in line with the evidence overall. They were the area where Health Boards scored themselves the lowest, recognising the work they needed to do to in these fundamental areas.

Key findings

Each Health Board recognised the need for further work across this domain and scored this overall lower than other domains.

Directors of public health are uniquely placed to advise each Health Board on inequalities in their local community, and we noted some areas of a good strategic understanding of their communities, however how they routinely captured data by protected characteristics routinely within perinatal services was less robust. It was felt that BadgerNet® Maternity and the recent additions to the maternity record would improve these data being captured more consistently.

What needed further consistent work was how the knowledge of their communities was, or should be, applied to inform their provision of perinatal services in a more intentional and targeted manner to reduce inequalities and improve outcomes for women and families. Furthermore, when we explored how Health Boards were measuring the impact of initiatives on inequalities in access and outcomes, they recognised this was an area that needed further development and focus within Health Boards and nationally. The known disparity in outcomes for vulnerable groups was not sufficiently influencing provision of care and oversight frameworks nationally.

One Health Board had completed a significant focus in understanding their population and created a Joint Strategic Needs Assessment (JSNA). However, this was in the early phases of implementation so impact could not be assessed.

There was work needed in some areas to ensure all communication was available in different languages across Health Boards. Some Health Boards had done a significant amount of work to ensure accessibility of key documentation, but triangulation of workstreams suggest there was more work to do.

One Health Board has driven a key improvement project to introduce an additional page in the women's pregnancy health record to improve the understanding of the woman's individual and wider family needs. This initiative has since been adopted nationally and is being included in the health record for the whole of Wales.

An area of focus that needed significant work was the proactive analysis of data by protected characteristic to allow Health Boards to understand any trends or changes in outcomes more effectively. Equally, this information was needed to ensure the impact of initiatives could be assessed and measured. These data needed to be more systemically tied into the oversight frameworks to ensure sufficient focus on outcomes. The implementation of BadgerNet® Maternity across Wales from April 2026 will provide an opportunity to capture data more routinely and scrutinise the findings according to protected characteristics and vulnerable groups.

Staff training and education was present but could be an area of significant strengthening including the understanding of the specific relevance of perinatal services in this area and the the known direct link to poorer outcomes for some women, babies, and their families. This strengthening needs to ensure any training/education of staff is meaningful in helping teams understand the link to outcomes and experience of care. The need to evaluate the impact of training and the consequent link to improving outcomes is an area for further consideration.

Domain 8. Learning, Improvement, and Innovation Capacity

Statements Scored in Domain 8:

8.1 Quality improvement is embedded in daily practice, supported by a clear organisational improvement framework, consistent evaluation and routine sharing of learning.

8.2 Staff are trained, encouraged, and supported to innovate and improve services, with recognition for successful initiatives.

8.3 Learning from internal and external reviews is transparent, shared and acted upon within defined timescales.

8.4 Successful improvements are sustained, scaled, and evaluated for long-term impact.

Overview of scores

The overall aggregated score for the whole of Domain 8 for each Health Board varied from an aggregated score of 2.8 to 3.5 and an overall average score of 3.2 for all-Wales.

The all-Wales score for each statement highlighted some variation as the scores were between 2.8 – 3.4.

Within these, all statements had at least a Health Board scoring a 2. Only statements 8.2 (staff training and support) and 8.4 (sustaining and scaling improvements) had a Health Board score a 4. Most scores across the statements in Domain 8 fall between 3 and 4 which suggests a high level of maturity.

Perspective on accuracy of scores

The self-assessment maturity scores for Domain 8 were higher overall than the evidence demonstrated. There were some scores from some Health Boards that reflected accurately their level of maturity and the recognition that even where there were positive examples, there was further work to do to embed a systemic approach.

Key findings

A culture of continuous improvement across perinatal services was not reported to be systemically embedded within Health Boards to enable teams to thrive, learn and innovate. There were some examples of where individuals or teams had the personal focus and determination, they would be supported to drive improvement.

Clarity on methodology and enabling functions to maximise the impact wasn't consistently understood by teams with systematic education in place. Staffing pressures were reported as one key factor limiting proactive time to ensure diversity of thinking and spaces to be curious and innovate were not routinely present in governance processes. These factors are key enablers to underpin a high performing learning culture, which also allows women and families to be involved in these processes effectively. This was an area where teams felt a systematic approach to an improvement methodology would be valued at a national level to allow all-Wales approach to learning and improvement. At an individual team and local level there were some good examples of positive culture where they were working collaboratively and innovating where their personal motivation was strong and they sought the necessary support.

Quality Improvement methodology was part of some Health Boards' strategy with evidence of a clear methodology being present, but it was not embedded into practice consistently across perinatal services. However, some Health Boards had made more progress than others. Whilst, in theory, there was an adopted methodology in some Health Boards, this wasn't being consistently used or encouraged as a routine method to encourage curiosity, drive improvement and learning across perinatal services.

Despite this, clinical leaders described some excellent examples of improvement projects having been completed, and clear impact and implementation of those projects. However, these were deemed to be more dependent on the enthusiasm of individual teams and staff and their determination to seek support, as opposed to the provider encouraging innovation proactively through a culture of innovation across the services.

Improvement projects were reported to be more prevalent in neonatal services than maternity services overall as the staffing pressures and rota gaps, particularly in obstetrics, resulted in minimal time to innovate and improve. One Health Board described the impact of staff shortages historically having prevented a culture of learning and innovation, and the positive shift when more support for perinatal services was focussed at board level.

Staff training on improvement methodology was inconsistent and there was suggestion within Health Boards that a national improvement approach would benefit staff, as it would be seen as a clear priority in perinatal services to deliver the necessary changes.

Learning from internal reviews has been covered in domains above and requires a more open approach to routine externality of perspective and systemic learning being more embedded in the culture and processes, as well as crucially involving women and families in improvement work.

Learning from external reviews is more systematic as this is driven more nationally by MatNeo SSP[1]. However, the learning from national incidents and external reviews at a national level is not consistently shared or scrutinised through a national oversight framework to ensure timely and meaningful implementation. Furthermore, evidence of how oversight of continuous improvement meets the requirements set out in the HCQS[5] was not sufficiently robust as an enabler of quality. Equally innovation tied to national learning was not considered by senior leaders to be present was not sufficiently robust as an enabler of quality. Equally innovation tied to national learning was not considered by senior leaders to be present.

National governance, scrutiny and planning

Information about these aspects has been gathered through a number of sources including a questionnaire to all national organisations with areas of responsibility related to maternity and neonatal services, feedback during site visits and staff consultations, and meetings conducted by the Chair with a range of key organisations. Details are in Section 2.

Financing and accountability of perinatal services.

Core funding for perinatal services is provided as part of the block grants to Health Boards, in response to their submitted Integrated Medium-Term Plans. This means that funding for perinatal services is not ring-fenced and there is no overall figure for spending on maternity and neonatal services in Wales.

There are some exceptions to this funding model. Firstly, some neonatal services are commissioned and funded by the NHS Wales Joint Commissioning Committee (see below). Secondly, since 2022 there has been a national Maternity and Neonatal Safety Support Programme[1] that has provided short-term, ring-fenced funding for specific posts and programmes.

Specific ring-fenced programmes funded by the NHS Wales Joint Commissioning Committee and Welsh Government, have clearer accountability processes. For example, the Maternity and Neonatal Safety Support Programme[1] for which the National Strategic Clinical Network for Maternity and Neonatal Services has been responsible since April 2024, has an Implementation Network with a Clinical Lead to oversee delivery of the improvement programme. There are also nationally funded improvement lead posts in every Health Board, although all posts are underpinned by short-term funding. There is also a bi-monthly Implementation Network Oversight Group (INOG) with all Health Boards, WAST, and key partners reporting regularly. The overall programme has seen measurable improvements in several safety processes and outcomes.

In contrast, much of the perinatal service is not directly commissioned and, as with other NHS block funding, levers to ensure accountability for maternity and neonatal services from Health Boards to Welsh Government are limited. There is a lack of a national accountability framework for perinatal services with measures set to national benchmarks to aid Welsh Government to hold Health Boards to account. The relatively recent Quality Statement for Maternity and Neonatal Services[2] has been an important step forward in setting expectations for perinatal services throughout Wales, and the Welsh Government set seven expectations for Health Boards to achieve in the statements' first year of operation. However, these lack nationally agreed indicators for benchmarking progress. For the last two years Welsh Government has held quarterly 'deep dives' with each Health Board to examine their available performance data in perinatal services and to discuss their plans to respond to any areas of concern. This has been a welcome improvement in prioritisation of perinatal services in the accountability cycle.

The NHS Wales Oversight and Escalation Framework[37] set out the Welsh Government's approach for gaining assurance from NHS Wales organisations; and the escalation and intervention processes where there are matters of concern that need to be addressed. Organisations can be in one of five escalation levels. Currently Swansea Bay University Health Board are in level four for maternity and neonatal services.

Further tools such as financial incentivisation for improving experiences and outcomes in perinatal services are currently only available to the Welsh Risk Pool.

Overall, the panel found national and Health Board accountability to be widely disseminated and difficult to discern, outside of specific commissioned programmes, as described above. One example of this is that Health Boards report staffing levels and sickness absences in several different ways, making it difficult to understand the national picture.

Information is lacking on whether, and to what extent, funding decisions take account of changing needs such as increased complexity of care, alongside evidence on what services should and should not be provided, and wider population factors such as health need, socio-economic deprivation, and geography.

Commissioning

The NHS Wales Joint Commissioning Committee (JCC), is a Joint Committee of the seven Health Boards acting collectively on their behalf, funded by the Health Boards with all seven chief executives on the committee. The JCC is responsible for commissioning specialist services for the population of Wales. This includes fetal medicine services which care for foetuses with complications while still in utero, and neonatal units which are currently funded through a neonatal cot day tariff which is dependent on the level of care delivered. The JCC funds the intensive care and high dependency cots, while special care is funded by individual Health Boards but administered via the JCC on a 'pass through' basis. The neonatal cot day tariff was increased in October 2022 to provide higher levels of staffing, but it is recognised that the tariff does not meet the needs for a fully multidisciplinary team.

The separation of neonatal cot commissioning could act as a disincentive to support transitional care and early discharge care-at-home services as these are not funded by/through the JCC.

The JCC has the remit to commission several other perinatal services; however, the strategic development of several important areas has been stalled for reasons that were unclear to the panel. These include:

- The commissioning of **acute neonatal transport services** in south Wales. The panel was surprised to learn that the commissioning arrangements for out-of-hours staffing for this service have been 'interim' since 2021
- A **Neonatal Transformation Programme**. Phase 1 which included the review and rebasing of neonatal cots across south and west Wales was completed in 2023 but has not yet been fully implemented. Phase 2 work is 'on hold'. Some Health Boards report that they are waiting for this work to be completed before making staffing decisions.

- **Maternal medicine**. The National Strategic Clinical Network for Maternity and Neonatal Services wrote a paper for the JCC in October 2025 recommending the development of a maternal medicine network in Wales stating that care for women with complex health conditions is 'fragmented and inequitable'. This network would ensure that standardised care is provided throughout Wales for pregnant women who live with complex conditions such as cancer and cardiac conditions. Many such networks exist in the rest of the UK with evidence that they reduce maternal mortality and improve women's experiences. While this case has been developed relatively recently and therefore cannot be classed as 'stalled', it appears to be a gap that should be considered urgently.

The JCC has several suitable mechanisms available to monitor outcomes associated with its commissioned services. There is potential for these mechanisms to be more clearly aligned with other national monitoring and accountability mechanisms to ensure that intelligence is shared effectively.

Health Education and Improvement Wales (HEIW) is the education commissioner for the NHS Wales pre-qualifying non-medical workforce and post-qualifying training for a range of health disciplines. HEIW advises the Welsh Government each year of the number of healthcare training places required to meet current and future NHS Wales workforce need. This includes both undergraduate and postgraduate professional education. Current commissioning figures for midwifery are drawn from Health Boards' estimates of what numbers they will likely need in three years' time. Methodologies for reaching these figures are not currently consistent across Wales. The panel has been informed that a HEIW Strategic Oversight Workforce group, incorporating all seven Health Boards, is about to begin work with an aim to improve national consistency and accuracy of workforce planning based on changing population needs.

Quality, safety and improvement

As the independent inspectorate and regulator of healthcare in Wales, Health Inspectorate Wales (HIW) has an important role in monitoring quality and safety. However, in practice, HIW has a relatively small role to play in perinatal services. Only 4-5 maternity units are inspected each year, with HIW reporting that they take a risk-based, intelligence-led approach to selecting units. HIW has never inspected a neonatal unit. The body has recently launched some new development work to explore options for improved approaches in perinatal services. The role and impact of HIW was considered by our panel to need review, regarding the inspectorate's legislative remit and powers within the wider oversight framework. It is acknowledged that this would be a wider cross-NHS legislative change, and therefore beyond the remit of our panel's recommendations.

At a national level, the monitoring of quality and safety, ensuring improvement where required, depends on high quality qualitative and quantitative data. In terms of quantitative data, it is important that high-quality, nationally consistent and contemporaneous data are available on safety and quality indicators including differential outcomes by population group or between clinical sites.

In neonatal services, real-time data are available on safety and quality indicators due to the established use of BadgerNet® which is an electronic health record for individual babies which can be monitored, and any potentially concerning patterns of outcomes identified quickly.

In maternity services, under a programme called Digital Maternity Cymru, BadgerNet® Maternity has recently been rolled out for all pregnant women in two Health Board areas, with the rest of Wales expected to have implemented by April 2026. A maternity and neonatal dashboard called the Beacon dashboard has been introduced to monitor data on patterns of care and outcomes at Health Board and national level, but the clinical dataset which will be incorporated into this at a national level is still in development. Clear monitoring and review plans will be needed to realise the benefits of this improved access to timely data. Work will also need to be done to ensure reliability of data, with some of our workstreams identifying emerging variation in BadgerNet® Maternity use between Health Boards. For a comprehensive overview it will be important to combine quantitative data with qualitative assessment of women and families' and staff views.

Digital developments represent a step-change in the potential for Wales's maternity and neonatal services to analyse delivery of care and outcomes and take prompt action when needed. However, pace of development for the national dashboard and clarity of purpose is required to ensure that this potential is realised.

A number of national bodies examine different elements of national and Health Board-level datasets, including the Welsh Risk Pool, the National Strategic Clinical Network for Maternity and Neonatal Services, HEIW, HIW and Welsh Government, but there is no formal group that brings together those groups to discuss patterns and outcomes and agree priorities for improvement. This form of intelligence-sharing is not only important for early identification of concerns, it can also identify successful or promising initiatives that can be rolled out nationally. In our assessment we have identified several promising local initiatives, but mechanisms to share and replicate innovation is limited.

Incorporating views and experiences of women, partners, families, and staff at a national level

As noted previously, understanding the views and experiences of those using and working in perinatal services is a vital part of quality and safety monitoring. Involving those groups in co-production of service improvement is essential to ensure that the impact of change is thoroughly assessed, and implementation challenges foreseen.

There is a new emphasis on engaging women, parents, families and communities at a national level supported by the introduction of the Perinatal Engagement Framework[36]. A new national survey was rolled out during 2025 capturing broad experiential feedback from women at different stages of their maternity and neonatal journey.

Maternity and Neonatal Voice Partnerships (MNVPs)[38] are a relatively recent development in Wales, and they have a broad remit to engage with users of perinatal services and engage them in service development. They exist in five out of seven Health Boards, but their stages of development are varied and only two currently have paid Chairpersons, limiting the voices of women, parents and families into service planning, provision, and monitoring at present. All Health Boards are required by Welsh Government to recruit paid chairs by the end of March 2026. A national MNVP forum is being planned.

The ability to hear and understand staff and student experience at a national level does not yet have a similar perinatal engagement and involvement framework to the one now setting expectations for engagement with women, parents and families. Instead, this area is currently supported only by the broader all-NHS People's Experience Framework[11] which sets out general expectations for understanding staff experience and involving staff in service development. There is a national staff survey, but it has a low response rate. UK-wide mechanisms, such as the RCOG survey, provide important benchmarking opportunities and HEIW indicates that it investigates training sites where satisfaction levels are low in relation to the rest of the UK, as has been the case in some Welsh sites in recent years.

Learning from reportable incidents and reviews

In maternity and neonatal services, responses to patient safety incidents, from near misses through to perinatal deaths, are governed by a number of frameworks and legislation, including the Welsh Government recent overhaul of their legal process for managing complaints, investigations and redress in NHS Wales[39]. Duty of Candour legislation[33], the UK-wide Perinatal Mortality Review Tool (PMRT), Local Reportable patient safety Incidents and National Reportable patient safety Incidents processes. A Medical Examiner reviews all maternal and neonatal deaths that are not investigated by a coroner. Perinatal deaths have clear reporting routes, but reports must be made using multiple processes, including National Reportable Incidents, the Perinatal Mortality Review Tool and the MBRRACE-UK process.

Hypoxic-ischemic encephalopathy (HIE) is a type of brain injury, caused by a lack of oxygen to the brain before, during or after birth. HIE is not explicitly stated as a National Reportable Incident within the generic NHS Wales Incident Reporting guidance[40] which creates a risk that incidences of HIE may not be captured within national reporting.

A Standard Operating Procedure document, including a flowchart, for incident reporting in perinatal services in Wales would support staff to understand and fulfil their range of duties with Welsh and UK reporting guidance, including how and when to include families in the process. This inclusion must be meaningful and adopt restorative justice principles to avoid compounding trauma. It should also act as a fundamental part of the learning and improvement journey for services.

The Welsh Risk Pool (WRP) National Learning Advisory Panel (LAP) receives and reviews Learning from Events Reports (LFER) for every claim and redress case in Wales. They have financial mechanisms to incentivise timely completion of these reports, but experience often lengthy time lags in receiving them due to issues such as difficulties in securing suitable external experts to review evidence. The National Learning Advisory Panel monitors Health Boards' responses to actions identified in individual learning from events reports.

There are national learning forums for some types of serious incident, including hypoxic-ischemic encephalopathy and neonatal death, but not for stillbirth and maternal mortality. There is a national repository of National Reportable Incident (NRI) reports into the NHS Wales Beacon dashboard. This is for NRIs across the whole of the NHS and doesn't include locally reported incidents. Although there is an annual thematic report from this repository, it covers all areas of NHS provision. Efforts to draw together thematic learning on perinatal incidents is currently limited, therefore, by the lack of a specific perinatal repository and the lack of inclusion of reviews that did not reach National Reportable Incident status.

Relationships between national bodies

Relationships between national bodies with responsibilities for perinatal services as part of their remit are generally described as positive. Nonetheless, most national body leaders that have contributed to this assessment agree that there is potential for greater clarification of the role and responsibilities for some bodies, including NHS Wales Performance and Improvement and, within that, the National Strategic Clinical Network for Maternity and Neonatal Services, to clarify accountability mechanisms. They also agree that more formal opportunities to share analysis and discuss trends would support the setting of national priorities. Executive and senior clinical teams in Health Boards similarly report that such clarification is needed.

For example, there is no publicly available document that describes the specific roles of each national body with responsibility for accountability in perinatal services, nor of how they relate to each other and to the Health Boards and other providers, to create a coherent national governance structure. A second example is that there is no structured approach to sharing and using national intelligence and data or planning and implementing improvement across organisations. Health Inspectorate Wales facilitates a national summit twice a year that brings together national bodies in health care, but this is not focused specifically on perinatal services, and it is a voluntary arrangement.

Finally, there are national meetings between clinical leads, such as Directors of Midwifery, Heads of Midwifery and Lead Midwives for Education and Executive Directors of Nursing, but fewer opportunities for multidisciplinary sharing at a national level.

Section 7: 15 steps site visits

Approach

Our clinical site visits aimed to examine services under everyday conditions. By providing a current snapshot of operational reality, we could examine how clinical pathways, staffing models, estates, and governance interact to shape outcomes and experiences, showing what works well and where risks may emerge. The 15 steps clinical site visit methods were based on an adapted version of the NHS England 15 steps challenge[12], which aims to explore healthcare settings through the eyes of the user to understand improvements that could be made as well as areas that work well. It was adapted to include structured clinical prompts and key lines of enquiry to allow deeper exploration. Assessment criteria were agreed, and an observation tool was developed to ensure standardisation across all site visits and reduce operator bias. For details see Section 2.

The visits focused on a variety of areas, including antenatal clinics, triage, standalone and alongside midwifery units, labour wards, recovery, ante and postnatal wards, transitional care and neonatal units. Insights were used to:

- Highlight and share examples of good practice
- Identify areas requiring improvement and action
- Provide assurance that women, parents, families and babies voices are systematically embedded in service design, delivery, and governance processes.

Eighteen site visits were undertaken over a period of three weeks. The key themes for Wales were identified and mapped to existing work where relevant.

Experiential Analysis

The experiential lens cannot be separated from the clinical focus when delivering high quality care; the following analysis aims to describe the national picture of the experiential findings across all the themes.

During the 15 steps site visits the overall experience was characterised by compassionate, person-centred care delivered by committed and approachable staff. Families frequently described feeling welcomed, supported and safe, with strong expressions of trust in the teams caring for them. Positive staff attitudes, kindness and continuity were consistently highlighted as significant strengths, often influencing women's decisions to choose or remain within a service.

Birth and postnatal environments demonstrated a clear commitment to supporting positive experiences and family involvement. Women and partners valued the calm atmosphere of birthing rooms in midwifery-led units, and several units enabled partners to remain for extended periods or continuously, reinforcing family-centred care. It was identified that the welcoming, calming environment typical of a midwifery-led unit could be replicated within obstetric settings to enhance the birth experience for all women and families. Despite many units having estate constraints neonatal and transitional care environments endeavoured to support parents to remain at the cot-side, with accommodation and reclining facilities enabling closeness and participation in care. A notable bright spot observed in one Health Board was the introduction of bluetooth-enabled access for families entering the Neonatal Unit, replacing the traditional need to ring the bell and therefore enhancing the experience for parents.

Staff culture emerged as a consistent and powerful strength across most units. Teams were described as friendly, approachable and proud of the care they provide, with strong multidisciplinary working evident. Concerns were expressed regarding behaviour and team dynamics within certain units.

Women, parents and families frequently commented on feeling listened to, having their choices respected and receiving clear explanations about their care, particularly around induction of labour and complex decision-making. In contrast there were incidences where poor experiences had occurred in these areas. Continuity of care, especially where community and ward teams worked closely together, enhanced confidence and reassurance.

Welsh language provision was a notable strength in many areas, particularly where the workforce reflected the local population. Interpretation services, including face-to-face interpreters and digital platforms, were used to support families whose first language was not English with examples of effective communication for parents who use British Sign Language. There was clear evidence of experience and commitment in supporting accessibility and inclusion. Staff described adapting care for parents with sensory impairments, physical disabilities and additional needs through personalised planning, preparatory visits and flexible communication approaches.

Conditions varied significantly both across and within Health Boards, with marked differences in the physical environment and available facilities along the perinatal pathway. In units with a low ante/postnatal bed-to-birth ratio, staff reported that this negatively affected patient flow and clinical pathways. While many clinical areas were clean, calm and well maintained, several units operated within older estates with limited space and storage. This resulted in cluttered corridors, equipment stored in public areas and environments that felt clinical or dated. Arrival areas and wayfinding were a recurring challenge, with unclear signage, confusing access arrangements and first impressions that did not always convey a clear identity. Staff frequently described long-standing estates issues, noting good working relationships with estates teams but a need for sustained investment.

Bereavement care and support was generally described as compassionate and respectful. Dedicated bereavement rooms or suites were available in many settings, often refurbished with charitable funding, although soundproofing, location and availability varied. Where dedicated spaces were not available private rooms were utilised to support dignity and confidential conversations. Staff reported that families valued the quiet, supportive approach taken during difficult circumstances.

Practical support for families was a notable strength in many areas. Access to kitchen facilities, refreshments, accommodation and flexible visiting arrangements supported family presence and reduced stress during prolonged stays. Neonatal and transitional care areas demonstrated strong commitment to Family Integrated Care principles, enabling parents to remain close to their babies for extended periods.

Across the system, one of the most consistent and impactful strengths observed on the site visits was the compassion, adaptability and professionalism of staff. Variations in physical environment, signage, information clarity and accessibility influenced experience at times, but staff were observed to mitigate these through warmth, care, and occasionally personal action, for example by raising money or applying for grants for parent facilities and bereavement rooms.

Key Themes

The site visits analysis identified nine interrelated themes. The themes are not identified in priority order, together they describe the quality and safety areas that are working well and could be replicated elsewhere or areas that may need a local and/or national improvement focus.

Staffing and capacity

What we found

The negative impact of staffing pressures was identified throughout all site visits. This is closely linked within all the other themes and may impact the ability to provide a consistently safe, quality service. Some of the areas that were identified within staffing were:

- Out of hours medical cover for all specialities, with the exception of neonatology, was inconsistent.
- There was variation in the time obstetric consultants are resident out of hours after 17.00 and at the weekend. Some rotas have a mixed model of obstetric consultant and resident doctors delivering out of hours shifts. Where units have consultants covering obstetrics and gynaecology out of hours, there was variation in the consultants' daytime commitment to maternity. There was also variation in the number of clinical areas a consultant on call for labour ward during the day covers, with some also covering one or more of gynaecology service, antenatal and postnatal wards, and clinics.
- Inadequate skill mix within the midwifery and neonatal nursing workforce was described by many staff and witnessed during the visits. Staff described the streamlining process as contributing to this, resulting in a larger proportion of newly qualified band 5 midwives, leading to an inability to recruit into more experienced band 6 roles. Experienced midwives described the added pressures of supporting large numbers through their preceptorship period (a structured phase of guided support designed to help newly qualified midwives consolidate skills, develop confidence, and transition safely into autonomous practice). This increasing demand on senior staff was highlighted as a significant strain on the service.

- The neonatal service described a shortage of nurses that were qualified in speciality (QIS) due to several reasons including the time to complete the training and a reluctance to complete the training due to not wanting to take on the extra responsibility this brought.
- There is an overall shortage of all staff groups, including midwives, allied health professionals, medical staff (obstetricians, neonatologists and anaesthetists) pharmacists and psychologists. This was overwhelmingly the most frequently raised concern across all site visits, with contributing factors including unsuccessful recruitment attempts, lack of available funding to support posts, and high sickness rates.
- A workforce that was frequently redeployed was described by many, meaning that staff were moved to ensure that areas with the highest acuity and risk remained adequately staffed. This often resulted in reduced coverage in other areas.

Bright spots

One Health Board has an established acute on-call midwifery model, enabling additional staff with the appropriate acute care skills to be deployed during periods of peak activity.

Another describes an additional check at the perinatal huddle to ensure that the nurse in charge of neonatal services 'feels the unit is staffed safely'.

Improvement opportunities

Each shift should include a supernumerary midwifery coordinator, in line with Birthrate Plus® methodology, and a supernumerary nurse overseeing neonatal units, as recommended by the British Association of Perinatal Medicine standards. These arrangements were not consistently in place across Wales. Also important is ensuring that the obstetric staffing model enables timely and equitable access to a consultant obstetrician both in and out of hours.

Triage

What we found

Triage services were available in all Health Boards but there was inconsistency in the provision of this service with staff describing a sense of vulnerability when emergencies occur and escalation is required. The location was often combined with other services such as day assessment units or antenatal wards leading to competing pressures on facilities and staffing. There was inconsistent provision of dedicated midwifery staffing and senior medical cover within the smaller units who were often covering other areas which took priority over triage, such as labour ward. Midwives were often expected to have more than one role when working in triage. Across Wales there was differing terminology used for triage services and what was provided in that area.

Bright spots

There is recognition that a national programme of work overseen and co-ordinated by the Maternity and Neonatal Implementation Network to implement the Birmingham Symptom-specific Obstetric Triage System (BSOTS) as recommended by RCOG, 2023 is at differing stages of implementation, but all Health Boards showed commitment to this.

Improvement opportunities

There is an opportunity to implement a standardised service model with consistent terminology, ensuring 24/7 availability supported by dedicated staff, reliable senior clinical presence, and a single, standardised phone access point.

Planned caesarean birth and theatre provision

What we found

All Health Boards described the number of planned caesarean births increasing however there was little or no increased theatre time to account for this increased workload: noting that Powys Teaching Health Board only provide low risk intrapartum care, caesarean births would be performed in a neighbouring Health Board. Staff described that workforce modelling had not considered the increase in caesarean birth and the impact this has on different professions. The data show that nearly half of all births are in a theatre setting (planned or unplanned caesarean birth plus many forceps or ventouse births and suturing), leading to the requirement for more theatre staff including obstetricians, anaesthetists, midwives, operating department practitioners and support staff.

Bright spots

Effective pathways were demonstrated in some units that had established planned cesarean birth lists, using general theatre capacity and staff and dedicated midwifery and obstetric staffing.

Improvement opportunities

Not all facilities were fit for this changing model of care. Physical space including recovery areas and number of theatres needs to be reviewed in many Health Boards, as well as the unique requirements for obstetrics such as placement of resuscitative equipment.

Planned caesarean births are not consistently separate to the emergency workload which can lead to delays and cancellations as well as competing priorities of the same workforce. Having a separate planned workstream with associated workforce in a designated space was described as a model to aspire to by all Health Boards that provide caesarean births.

Induction of labour

What we found

There were notable inconsistencies in the induction of labour pathway with labour ward activity impacting on these pathways, flow and ultimately women's experience and outcomes. Staff described inductions being delayed or cancelled due to labour ward acuity.

Bright spots

Direct admission to a designated clinical area with designated staff and induction of labour capacity included in daily safety huddles have been achieved by some Health Boards. In addition, some labour wards maintained continuous oversight of all ongoing induction of labour procedures, ensuring that activity was monitored in real time and considered alongside wider ward pressures. This oversight was incorporated into multidisciplinary handovers to support appropriate prioritisation of care.

Improvement opportunities

There is an opportunity for Health Boards to align themselves with the most up to date guidance through a clear national service specification to ensure informed decision making, planning and timely access to care that aims to improve the birth experience for all. This will ensure that practice is aligned with the most up to date, evidenced based guidance.

Neonatal Care Pathways and Transport services

What we found

Neonatal service provision across Wales appears to be characterised by a clear division between the North and South regions. The three units in North Wales (which operate within a single Health Board) reported strong collaboration and effective alignment with neighboring English trusts. In contrast, networking and coordination between neonatal units in South Wales were observed and described by staff to be considerably more fragmented.

Wales appears to have a comparative excess allocation of neonatal cots, in particular special care cots and neonatal intensive care units; however, In South Wales the current configuration of neonatal services is marked by fragmented coordination, inefficiencies in service organisation, and unclear interdependencies between units. Wales is distinctive in having three NICUs located in proximity within South Wales but no designated Local Neonatal Units, a configuration that differs markedly from the rest of the UK and creates challenges in establishing reliable and coherent national care pathways. Collectively, these issues affect the equity, consistency, and overall experience of care for women, parents, babies and families. All neonatal units in the region expressed an urgent need for the Joint Commissioning Committee (JCC) to expedite its commitment to undertake strategic planning regarding the service model and designation of cots, to support the development of a more efficient and sustainable configuration. For reference, neonatal pathways in North Wales operate differently; care is aligned with NICUs in England and supported by a single Sub Regional Neonatal Intensive Care Centre (SuRNICC) which is a unique model to Wales.

In addition, staff reported that fetal medicine services in North Wales do not align effectively with the existing neonatal intensive care configuration, resulting in further challenges to pathway coherence.

The Cymru Inter-Hospital Acute Neonatal Transfer Service (CHANTS) in South Wales is staffed by consultants and nurses from the three NICUs on a rotational basis, which some staff reported as impacting unit staffing. This concern appears primarily linked to the interim 24-hour model introduced in 2021, and the variation in service specifications between in-hours and out-of-hours provision. Special Care Baby Units (SCBUs) in South Wales noted inconsistent levels of support from the transport service during out-of-hours periods, resulting in inequities in care.

Bright spots

Staff across the neonatal service described team working as a significant strength. Most units also reported noticeable improvements in the perinatal working culture over recent years, attributing this to factors such as new governance arrangements, joint simulation and training sessions with maternity, transitional care improvement work, and Advanced Neonatal Nurse Practitioners.

Improvement opportunities

Clinical teams reported an urgent need for the JCC to accelerate its commitment to undertake comprehensive strategic planning for the future service model and the designation of cots, including considerations related to the transport service which may include an overarching national approach to neonatal transport. This work is essential to establishing an efficient and sustainable configuration capable of supporting optimal outcomes for mothers and babies across Wales. It was also recognised that this planning cannot be undertaken in isolation and must be fully integrated with maternity services.

Panel observations and discussions with neonatal clinical teams highlight the lack of an operational delivery network in south Wales to manage flow and capacity across neonatal units, strengthen clarity of roles, and ensure alignment of maternity, fetal, and neonatal pathways. In north Wales there is a clear opportunity to also include consideration of optimal shared care arrangements with NHS England (NHSE).

Neonatal Community Outreach Services

What we found

Neonatal community outreach services provide specialist support to babies and their families at home or in the community after discharge from neonatal services. Across Wales they operate with significant variation and limited availability during evenings or weekends. The range of care that can be delivered in the community also differs with many units aspiring to extend the scope of this service. Staffing models vary considerably, with some Outreach staff being redeployed during periods of service pressure and others undertaking dual roles within SCBU teams, reducing consistency and capacity.

Bright spots

Several NICUs had an integrated management team which included a dedicated manager with responsibility for Special Care, Outreach and Transitional care services and this was reported to work well.

Improvement opportunities

There is a clear opportunity to enhance Neonatal Outreach services through alignment with the BAPM Framework for the delivery of a Neonatal Outreach Service with protected staffing and consistent categories of care.

Transitional Care

What we found

Transitional care refers to the provision of neonatal care for babies who require extra support but do not need admission to a neonatal unit, enabling them to remain with their mothers. Babies requiring transitional care were frequently looked after within special care areas or within a postnatal facility with limited neonatal nursing input due to the absence of consistently established transitional care services. Provision of neonatal transitional care demonstrated significant variation across Health Boards, with some not offering the service. A standardised model was lacking, particularly in relation to governance and skill mix. This inconsistency adversely impacted key objectives, including keeping mothers and babies together, ensuring continuity of neonatal care, and supporting early discharge pathways.

Despite significant benefits, most services reported challenges in prioritising transitional care due to workforce and estate pressures. Staff were frequently reallocated to other areas during periods of high demand, further compromising service continuity. Additionally, management structures for routine clinical care, operational oversight, and professional leadership were inconsistent and, in some cases, unclear particularly when staff redeployment occurred.

Bright spots

Where transitional care was reliably implemented, both families and staff reported positive experiences. The most effective model had a dedicated area on the wards, staff specifically allocated in the numbers, a multidisciplinary team, and an integrated management team that also managed SCBU and neonatal outreach services.

Improvement opportunities

Observations and discussions with teams highlighted the need for transitional care to be delivered consistently across all Health Boards in alignment with the BAPM Framework for Transitional Care, which has been incorporated by the National Strategic Clinical Network for Maternity and Neonatal Services into the Transitional Care Service Specification for Wales. This approach provides clear guidance on governance structures, workforce requirements, skill mix, and safe inclusion/exclusion criteria but appears to not yet be operational in Health Boards.

Postnatal Care

What we found

In many Health Boards staff reported that the postnatal ward experience is summarised as a constant operational pressure due to the high occupancy, high turnover and unpredictable activity from labour wards. Staffing levels are often said to be insufficient, with midwives regularly reallocated to work in other areas, specifically labour ward, leaving limited cover and increasing workload intensity. Increased rates of operative birth have increased the need for care, but there has been no formal reconsideration of the workforce requirements to address this. Midwives explained that delays in medical reviews added further strain. Overall, the combination of high clinical need and continuous bed pressures result in ward environments where staff work reactively and feel stretched across competing priorities, and where the needs of women and babies for postnatal care are not being met.

Bright spots

In Health Boards where the bed to birth ratio was more favourable, the operational pressures observed elsewhere were significantly reduced or not evident.

Improvement Opportunities

Postnatal care requires adequate staffing to ensure that women and babies' needs are met in this crucial time.

Governance

What we found

Governance processes varied significantly with immediate local pathways clearly articulated across perinatal services, however this lacked consistency. There was variation in the management levels within the governance structures, with many layers of hierarchy in some Health Boards. Very few could articulate the national governance structure including the remit of the maternity and neonatal network.

Senior clinicians were able to describe local governance processes in place for perinatal mortality and risk reviews which were reported to involve families; however, these processes varied between Health Boards. It was noted by staff in all Health Boards that there was little or no externality for review of national reportable incidents and they recognised that this was a gap and an area to work towards.

Currently, maternity health records in Wales are recorded in varying formats, creating inconsistencies in communication and data accuracy. These challenges are amplified when care is shared with other Health Boards or trusts, where different systems and standards are in use. Historically, women in Wales have carried paper-based maternity health records throughout their pregnancy journey.

Recently, two Health Boards have transitioned to an almost paperless electronic system, significantly improving accessibility and efficiency within their own regions. However, these systems are not interoperable, meaning other Health Boards cannot easily access the records. This fragmentation creates

risks for continuity of care, particularly when women move between Health Board areas or require cross-border services. All Health Boards have expressed a clear need for a unified electronic maternity record system across Wales.

Bright spots

One Health Board described an effective governance process with corporate oversight and a clear pathway.

Improvement opportunities

Clinical teams reported that they would value standardised descriptions of perinatal leadership team roles and responsibilities, supported by simplified national governance pathways that provide clearer delineation of organisational roles, responsibilities, and accountability.

Summary

Staff across perinatal services described ongoing staffing shortages that affected reliability, flow, and safety, with variation in consultant obstetric cover in smaller units. These pressures were linked to inconsistent approaches to maternity triage, induction of labour, and theatre availability, and the number of Health Boards and individual units.

During the visits, teams frequently referred to significant capacity and sustainability pressures within South Wales NICUs and noted that delays in progressing the NHS Wales JCC Phase 2 neonatal configuration work were contributing to ongoing challenges.

Variation in Transitional Care and Neonatal Outreach provision was a recurring theme. Where services were limited, staff reported increased admissions, additional pressure on midwifery staff and neonatal units, and more frequent separation of mothers and babies.

Across Health Boards, staff also highlighted a lack of clarity around organisational roles and responsibilities and noted inconsistencies in perinatal mortality review processes, and particularly regarding externality, family involvement, and how learning was embedded.

Section 8: What we have learned

Why maternity and neonatal care and services matter

What happens in maternity and neonatal care will affect women, babies, partners and parents, and their wider families for the rest of their lives. It has the potential to shape their future positively, promoting the woman's physical and psychological health and well-being, ensuring the best start to a new life for the baby, and creating the best conditions for attachment and the start of new family relationships. When there is loss, the right care can hold and support families as they absorb what has happened and start to heal. Maternity and neonatal care help to create a foundation for positive early years development and for long-term population health. When that care is insufficient or inequitable the physical and psychological harm can be profound and have a lifelong impact.

The physical and psychological health of the staff who care for women, babies and families also matter, as people, they matter in their own right. They are also a valuable resource. Every day, they are in a position to prevent and treat problems and support women and partners/parents through a life-changing experience - or to contribute to harm. Working in this field is both intensely rewarding and intensely challenging. All staff need the full support of a well-functioning system to keep them safe and to enable them to provide the best care.

Conducting this work

Unlike previous reports which examined failures, we were asked to examine the whole system that provides care and services across the maternity journey for women and families in Wales, and to learn from strengths as well as for problems. Our focus was to identify solutions to inform future developments, and women, partners, parents and families, staff, and organisations welcomed that approach.

We conducted the work in five interconnected workstreams, each using a different approach to examine the system from a wide range of perspective. This multiple lens has allowed us to see many different parts of the system and to compare and confirm our findings. There was a very positive response to our engagement and as a result all five workstreams met their aims.

All Health Boards and national organisations participated, responded to our questionnaires, and supported our work in visiting their sites. In our engagement work we heard from more than 200 women, partners, parents and family members from diverse socio-economic and ethnic backgrounds, with outcomes and experiences that ranged from very positive to those with very difficult experiences of care and services. Over 400 multidisciplinary staff spoke with us or wrote to us about their experiences, as well as organisations with a role in providing and supporting the services, community and advocacy groups, and stakeholders from across the sectors in our consultative and stakeholder groups. All were willing and motivated to interact with our work and to help to improve services. Staff from all groups engaged positively, again with a willingness to contribute to and participate in future improvement. We are very grateful for all the input and support we have received throughout this work.

Sections 3-7 of this report have presented descriptive findings from our workstreams, each one written by the individual panel members who led that work.

Each of the workstream descriptions provide valuable evidence in their own right about the current quality and safety of maternity and neonatal services in Wales. However, each has limitations when taken alone. We have therefore cross-checked our findings across all our data sources, using three analytic steps.

First, each workstream presented their findings to the whole panel and identified key strengths and weaknesses in the current system according to their workstream data.

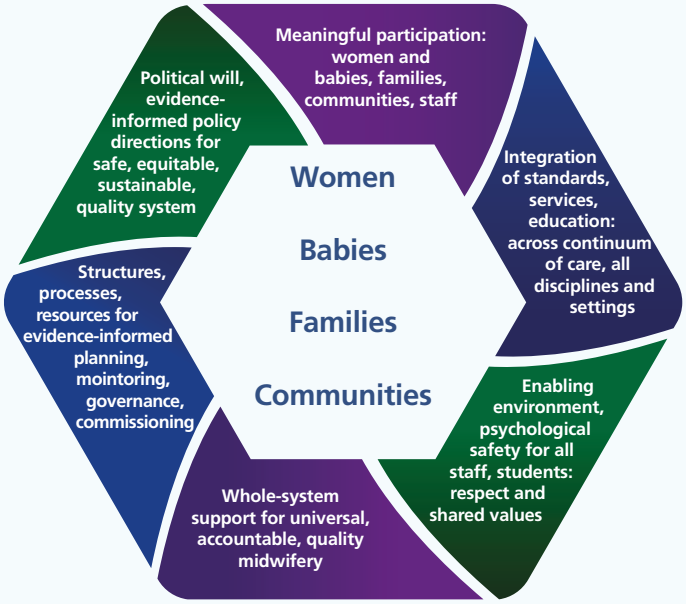
Second, we turned to the framework 'Key conditions for safe, quality midwifery and wider maternity care and services in all settings' (Table 1). This framework was developed by one of our panel members Professor Mary Renfrew who led a recent review of midwifery services in Northern Ireland[6]. This framework was considered suitable for aiding our analysis because it is recent (October 2024), based on UK practices and experiences, and draws on recent systematic high-quality research evidence. Although it emerged from a review of midwifery specifically, it took the wider maternity and neonatal system into account and is a whole-system framework that is suitable for analysing quality of care in maternity and neonatal care and services. It enables an analysis of strengths and problems as well as gaps in provision.

As a panel, we mapped our findings from each workstream to the framework in a two-day in-person analysis meeting.

Third, we cross-examined our emerging findings against the Quality Statement for Maternity and Neonatal Services[2] to ensure they are centred in the Welsh context. We also sense-checked our emerging findings with our Women, Family and Communities Consultative Group and our Stakeholder Panel on several occasions and their helpful insights helped to refine our thinking.

In this section we present a summary of cross-workstream findings against the Northern Ireland-developed framework.

Figure 9: Summary of key conditions for a quality maternal and newborn health system[6].



Cross-cutting theme 1: Core focus on respectful, individualised care and services and partnership working for all women, babies, families across the whole maternity journey

Strengths

The great majority of women responding to the recent National Women and Family Experience Survey of experiences (Section 4) reported being treated with respect, dignity, kindness and compassion by staff in both maternity and neonatal care. Reports of their experience of neonatal care were overwhelmingly positive.

In our engagement work we heard positive recognition from women and families of personalised care by midwives. On our site visits in maternity and neonatal care (Section 7), nearly all women and partners we spoke to were positive about the care they received from multidisciplinary staff, and many described feeling safe, with some exceptions. Staff who talked with us recognised that improving continuity and individualised care was important. Some reported to us how they have worked together to organise their services to maximise continuity of care and they requested a clearer consistent framework to support them in providing this.

Some local examples were observed of multidisciplinary working to support women who wished individualised care that was 'outside of guidance', but this was variable.

Many women and parents who had experienced bereavement care and support described their care as generally being respectful and compassionate, and some families with experience of perinatal loss described having good experiences of care from staff who supported them. Several of these families wished to draw on their experiences to contribute to improving care.

During site visits, we heard consistently that where clinical psychology services were available within maternity and neonatal units, they were considered invaluable in supporting both families and staff. More broadly, we observed positive examples of trauma-informed care across several sites, including thoughtfully designed bereavement suites, access to birth reflections services, and caring, respectful interactions.

Neonatal units had facilities for families with prolonged stays, including kitchens and accommodation. In our site visits we also observed a strong commitment to keeping mothers and babies together, to Family Integrated Care, and to fathers as partners in care. We observed 24-hour access to food and drink supplies in many maternity units.

Throughout our work we found that there was Welsh language provision for those who wished, and good examples of interpretation being available for those whose first language was not English or Welsh. We saw several examples of sensitive adaptations to enhance accessibility and inclusion for those who needed through personalised planning, preparatory visits and flexible communication approaches.

Areas for improvement

Assessment of women's, partners' and parents' views

In contrast with the positive survey responses to being treated with respect and dignity, women's ratings of their overall experience of maternity care were lower, especially when measured several weeks after birth. This suggests that the limiting factor was not staff attitudes but the structural constraints to quality care provision, aligning with the findings of our analysis of recommendations from previous reports (Section 3). In-depth insight into the views and experiences of women and partners is limited, however. Response rates to the perinatal survey are low, it is not clear how generalisable the respondents are, and questions do not allow for detailed responses. This is the first time such a survey has been run, and it may be possible to address these issues. Other ways of assessing views focus on individual incidents and complaints, and there was no mechanism for fathers and partners to contribute their views.

Experience of perinatal loss

While some families described excellent care when they experienced loss, we have heard from families that responses to serious incidents such as perinatal deaths and serious injuries to babies at birth can rapidly become a distressing experience (Section 4). Their immediate grief and trauma are compounded when experiencing a lack of involvement, bewildering processes, lengthy delays, a lack of clear understanding of what happened to their loved one and why it happened, and sometimes extensive legal costs. There was a lack of a consistent, supportive, trauma-informed approach when babies died. There is a clear need to clarify processes and to support parents throughout.

Equity and inequalities

The data in Section 3 indicated that inequalities in outcomes persist, especially in relation to ethnicity and deprivation. We listened to the experiences of women and families from a range of cultures and from areas of deprivation (Section 4). We heard positive examples of care. There were also examples where we heard of brusque interactions with staff, a disregard for women's views, a failure to explain and a lack of warmth. Gaining consent was complicated by language barriers and appropriate resources were not always available. The mental health of both mothers and fathers was raised as a concern.

Community groups were an invaluable resource for a diverse range of communities and there is potential to engage them more actively in planning accessible appropriate care for all. There were examples of initiatives where staff were implementing care for women, babies, parents and families from diverse communities including specialist midwives who provided services for a range of social and health complexities, but for the most part these were not funded securely and the changes in services, behaviour and communication needed to ensure cultural safety for all were not mainstreamed.

Continuity across the maternity journey, person-centred care

A fragmented task focus, rather than individualised care across the whole maternity journey, emerged in several workstreams. This was especially evident for women with more complex needs, who described less opportunity for informed decision-making and for building trust.

Women and partners described more task-driven conversations with doctors, although there were good examples of some doctors meeting women's individual needs. Continuity of midwifery care was very limited despite women's preference for this form of care and the strong evidence for its effectiveness especially for women from disadvantaged groups[41]. Triage services, which are crucial when responding to emergency situations, and where women and partners were very likely to be especially stressed, were particularly identified as not consistently providing person-centred care.

We heard from staff that there is a mismatch between women's wishes and expectations of individualised care and the services and staff available (Section 5). There were good examples of multidisciplinary teams working to support women who wished to have care that differed from the protocol or pathway – known as 'out of guidance' care – but this was not consistently available.

Respectful care

We heard from women who described not being listened to, their rights, needs, and preferences disrespected, and the use of dismissive and judgemental language. There were examples where the issues were of critical safety resulting in adverse outcomes, such as symptoms not being responded to. There were also examples where the issues did not involve critical safety, but which were distressing to women, such as limited family visiting. Women and staff reported that women felt unsafe when they could see and hear that clinical staff disagreed with each other. Some women from diverse cultural backgrounds experienced a lack of respect for and understanding of their needs and wishes, with distressing examples, and language barriers and issues around consent.

Information, education, consent and decision-making

Consent and informed decision-making were a particular concern for women, especially regarding induction of labour where some reported feeling pressured into agreeing without adequate information or discussion, although there were examples where women described having their choices respected and receiving clear explanations. Women's negative experiences are likely to be a consequence of factors including the increased number of inductions (Section 3), the lack of staff time for evidence-informed discussion, and inadequate staffing and beds to accommodate women receiving this intervention (Section 5, 6,7).

Women wanted to have the opportunity for discussion and information in pregnancy, and for antenatal classes to enable their informed decision-making, but such resources were limited. This is especially important considering the rapid increase in induction of labour and caesarean birth, both planned and unplanned (Section 3). This increase in interventions is also resulting in increased post-surgical needs for women including pain management, infection, haemorrhage, and increased mental health needs following complex births.

Women and staff talked about the importance of group antenatal opportunities for both peer support and education[42]. Much antenatal education is now delivered online, with limited in-person opportunities. This loses the multiple benefits of peer support, and women may not gain the evidence-based information that would support informed decision-making and counter misinformation on social media. It also risks excluding women who may not have easy access to online resources because of socio-economic, educational, language, or cultural constraints.

Postnatal care, physical and mental health

Women and babies' postnatal safety, health and the quality of postnatal care across hospital and community settings were identified as areas of concern across several workstreams. Postnatal care was described as transactional rather than personalised, with very limited time by midwives to care for women. The very limited postnatal care of women and babies seemed to be a compound problem resulting from the increased physical and mental health postnatal needs following caesarean birth and other difficult labour and birth experiences, staffing constraints as midwives are reallocated to labour ward, and a lack of community support. At the same time, fathers/partners reported feeling 'invisible', being excluded and not acknowledged at this important time for family attachment. They said they could be a source of help to postnatal services but reported being sent home after visiting hours.

We heard of unmet needs for psychological support for both women and partners, with difficulties accessing care and long waiting times. Many attributed their mental health needs to the care they received, and there is a special need for support for those who experienced perinatal loss and difficult births. We heard that when things go wrong, parents expect and need to be given information promptly and not just use the complaints process. They want and need more explanation of what happened before leaving the hospital, and basic errors need to be identified and corrected. We saw inconsistency in the involvement of women and clinicians in review processes.

Care and support for breastfeeding women

Breastfeeding clinics were reported to be well attended, and several teams demonstrated innovative approaches such as early post-discharge telephone calls and parent-focused facilities, including breastfeeding rooms and storytelling spaces. Despite this, breastfeeding care and support was identified by women and staff as a particular problem. Although initiation rates have risen steadily (Section 3), many women continue to encounter problems and discontinue in the early days and weeks.

Engagement with and support for community groups

Women and families saw community care and support groups as an essential component of care for both parents, especially for those with babies who had been in neonatal care, for those who are breastfeeding, for fathers, and for those living in complex social circumstances. Where these groups exist, there is insecure funding and inequitable access. There is a missed opportunity to integrate care and support planning more systematically with Flying Start, which offers comprehensive early years support for families living in disadvantaged areas, and to maximise the contribution of the community and voluntary sector.

Cross-cutting theme 2: Meaningful participation of women, babies, families, communities and staff

Strengths

In our work we found consistently that women, parents and families want to engage and to use their experience to improve care and services. We found some good examples of engagement with Health Boards, though these were driven by committed individuals, not by effective structures.

The consultative group we established to hear the views of service users, community groups, and staff proved to be an effective mechanism for the active participation of a range of stakeholders, where they could share their perspectives with each other as well as with us. This group has potential to continue to inform the implementation of changes in the future.

The Quality Statement for Maternity and Neonatal Services[2] require the meaningful participation of service users, and the Perinatal Engagement Framework[36] was established recently to ensure that the perspectives of women, parents, staff and students are systematically embedded within service evaluation and improvement processes.

Areas for improvement

Mechanisms and resources for meaningful participation of women, parents and families

We saw few signs of active participation of women, parents, families, staff or students in the planning, provision and review of maternity and neonatal services. The Perinatal Engagement Framework is a relatively new and positive development which is yet to be fully established. Appropriate resource will be needed to ensure its effective implementation locally and nationally, and to enable all voices to be heard.

Developing effective, equitable, and sensitive mechanisms for the meaningful participation of women, parents and families is essential. In our engagement work we found that invitations to organised sessions in health service sites did not work well; few people attended. Changing our approach to contact women, parents and families through pre-existing community groups and arranging for our panel members to meet with groups attending existing forums was much more successful. It enabled women, parents and families to engage on their own terms and to ensure reach, diversity, and openness. There is potential to use this approach for ongoing engagement.

We heard from families who had experienced loss. These individual sessions were in response to their requests, and the panel members who met with these families were experienced and trained in working with distressed and traumatised people. All participants were strongly motivated by a wish to support our work and to inform improvement, but these sessions were always triggering for the families. It demonstrated how important it is to support these families at every stage if their voices are to be heard in the planning, provision and review of services.

Maternity and Neonatal Voices Partnerships (MNVPs) are the main mechanism identified by Health Boards and national organisations to promote participation of service users[38]. These groups, chaired by a service user and with cross-sectoral and multidisciplinary membership, are at an early stage of development in Wales. All Health Boards are expected to have a group established, with a paid service user Chair, by March 2026 but only two have this in place yet. Training for Chairs, essential to ensure effective leadership of these groups, is planned but not yet implemented. Work is needed to identify how Health Boards, executive directors, and managers and leaders of all professional groups, will engage meaningfully and ensure accountability for acting on their input. Our respondents were concerned that while having a paid Chair is a positive step, this is only remunerated at a Band 4 level and does not reflect the level of skill and responsibility needed. We saw no examples yet of strategic impact. An All-Wales MNVP panel is under discussion; this could help national oversight and consistent approaches if aligned with the Health Board MNVPs.

Mechanisms for staff and student participation

There is real potential for staff and student engagement to inform service improvements. It was evident throughout our work that staff knew what the problems were and had answers to many of the challenges but were limited in being able to contribute to decision-making.

But there were very limited mechanisms for staff and students' voices to be heard, and for their meaningful participation. There was very low participation in the staff survey, and it was not possible to distinguish between respondents from maternity and neonatal services. Staff reported that staffing pressures limited their engagement with national structures where those existed. There were examples of individual staff taking forward initiatives, but these were not embedded or sustainable. Respondents identified that more strategic staff participation is needed, both locally and nationally.

There were no mechanisms identified for participation of students, despite their importance to future developments, their unique view across different services, and their experience of working with a wide range of staff and settings. Educators and researchers also have essential perspectives to bring in regard to optimal educational interventions to support staff and the evidence base for safe, quality care and service improvement.

Cross-cutting theme 3: Integration of evidence-based standards, services, and education across the continuum of care and all disciplines and settings

Strengths

Good examples emerged across the workstreams, but these were not always consistent:

- We saw and heard that the Maternity and Neonatal Safety Support Programme[1] has influenced a positive shift towards integrated perinatal services and the inclusion of neonatal services in multidisciplinary teams. Health Boards told us that the programme was not gaining the traction it needs; some attributed this to insecure funding and programme staff being on short-term contracts.
- Staff culture was recognised as a considerable strength, with staff observed to be friendly, approachable, and to take pride in providing quality care. There were concerns about behaviour and team dynamics in some units however, and isolated pockets of staff dysfunction which were not always known by senior leaders.
- Midwifery-led units were consistently described as delivering compassionate, personalised and relationship-centred maternity care, supported by strong continuity models across many Health Boards. The environments were welcoming with facilities that effectively promote physiological birth. We were told that the welcoming, calming environment typical of a midwifery-led unit could be replicated within obstetric settings to enhance the birth experience for all women and families.

- Women reported that infant feeding support within these settings is particularly strong, benefiting from the calm, consistent and individualised nature of midwifery-led care. While outcomes specific to midwifery-led units have not been reviewed separately, they are incorporated within broader Health Board reporting. No specific concerns have been identified regarding the outcomes of midwifery-led care. However recurring challenges persist, described below.
- The community midwifery service is providing continuous care for mothers and babies from pregnancy through the first few days and weeks at home (Section 5). Community midwives offer antenatal checks, support home births, provide postnatal care and help families adapt until a health visitor takes over. Women and families described community midwifery in a mostly positive and warm manner specifically around personalised care (Section 4). They were observed to be engaged with diverse community groups. They were described as playing a central role in care planning, often acting as the first point of assessment before escalating cases to senior midwives or consultants. Collaborative working between community teams, consultant midwives, and external partners such as health visitors and liaison services was described as strong in several areas.
- Some Health Boards had arrangements in place to avoid community midwives being called in to labour wards to assist, but this practice was not embedded.
- Transitional care in postnatal wards for babies who would otherwise be cared for in neonatal units was an example of care that requires integration across maternity and neonatal services. It kept women and babies together, but it was vulnerable to staffing pressures and funding constraints, and a standardised model was lacking. Most services reported significant challenges of staffing and estates in implementing this care.

Areas for improvement

All-Wales system-wide coordination

Wales is served by seven Health Boards and multiple hospitals, and we heard of widely varied experiences, practices, and resources both from women, parents and families and from staff. While local modifications are important to meet diverse needs, not all the variation can be explained by geographic and population diversity. We observed inconsistent models of care and varying pathways between Health Boards; examples included continuity of midwifery care, induction of labour, planned caesarean birth, triage, transitional care, and neonatal outreach care. Some of this variation was a result of geographical constraints but some seemed simply to be inconsistent practice and lacking a rationale. Integration of systems and standards and implementing effective change across these multiple organisations requires a clear framework, willingness to work collectively, and consistent monitoring and review. The National Strategic Clinical Network for Maternity and Neonatal Services was recognised by national and local organisations as a potential strength in supporting high quality integrated services, but it was noted by respondents that it was not fully multidisciplinary, that there were gaps including maternal medicine, and that it did not have the level of authority needed to require changes to be made.

Multidisciplinary team working

Multidisciplinary team involvement was evident in several care pathways, with obstetricians, midwives, neonatal specialists, and community teams contributing to planning where clinically indicated. Many services emphasised a collaborative ethos, with senior midwifery leadership providing strong oversight. However, multidisciplinary team engagement was not universal; some areas reported minimal or absent multidisciplinary involvement in specific pathways, indicating potential opportunities to improve interprofessional coordination.

Staffing, skill mix, and experience

Staffing problems emerged as the most consistent theme across perinatal services, with constraints at all levels directly influencing the reliability, flow, and safety of care. This was evident across all the workstreams, and for all professional groups including midwives, neonatal nurses, medical staff (obstetricians, neonatologists, paediatricians and anaesthetists), allied health professionals, pharmacists and psychologists.

Staffing shortages, rising clinical complexity, and environments not suited to current levels of complexity are placing significant strain on staff wellbeing and culture. Teams reported feeling overwhelmed and unable to take breaks, along with limited opportunities for learning, reflection, and participation in quality and safety work. Instability in senior leadership and a reactive culture were seen to undermine morale, psychological safety, and retention. Despite strong team-level cohesion, the workforce is increasingly constrained by pressures that affect wellbeing, hinder professional development, and pose risks to their health and well-being, service sustainability, and the quality of care. There is variation in how Health Boards calculate their required staffing levels and vacancy rates, and it is not possible to establish whether staffing is at safe levels. Better workforce models and accountability for safe staffing is needed.

Obstetric staffing is vulnerable with some units facing acute challenges despite a year-on-year increase in medical staff (Section 3). Despite good retention of resident doctors from Welsh national training posts, even recruitment of appropriately skilled consultants is difficult in a minority of units. Increasing complexity and intervention rates in obstetric care have placed additional burdens on senior staff with more complex antenatal care and an increase in both planned and unplanned caesarean births. The use of locums has been normalised, and there is concern about the need to build experience in small units. The sustainability and safety of the current obstetric rota was described as at risk due to a preference for gynaecology in some Health Boards. Some people are opting out of obstetrics in favour of gynaecology due to perceived negative aspects of obstetrics.

There is a shortage of speciality-qualified neonatal nurses, with the result that units are at times unable to meet the national British Association of Perinatal Medicine (BAPM) standards[43]. Services reported that this is driven by several factors, including the length of time required to complete Qualified in Speciality (QIS) training and a reluctance among some staff to undertake the training due to the increased responsibility it brings.

For midwives, we saw across the workstreams that there are not only insufficient numbers but also a marked imbalance between the number of newly qualified staff and more experienced staff. This risks inadequate support for staff who are developing their confidence, as well as support and supervision of students who spend 50% of their programme in practice. Midwives expressed pride in newly qualified staff and valued their role in nurturing future practitioners.

The number of commissioned student places in midwifery has increased steadily in recent years to address the longstanding shortfall in numbers (Section 3) but this requires more time for their supervision from experienced midwives. There has been a national strategic approach to use Birthrate Plus® as the recommended workforce planning tool to guide midwifery staffing levels in each Health Board in Wales. National work has been conducted in conjunction with the Directors of Midwifery to add additional modules to account for time taken to provide for student supervision, provision of care for women choosing birth outside of guidance, complexity of antenatal care, and increased social need but this has not been consistently adopted. Despite Birthrate Plus® being a longstanding tool, its implementation has been questioned[44] and the experience of at least three Health Boards is that it has some flaws, including not recognising the importance of skill mix across the midwifery work force. We heard about limited confidence in Birthrate Plus® across maternity services and triangulation with other methods is being examined.

Wales has implemented streamlining for newly qualified midwives and nurses, an arrangement where they are all guaranteed jobs when they qualify on a minimum 0.6wte contract. This is a positive development that avoids the problems in other UK countries where new graduates cannot find jobs, and it is likely to promote recruitment and retention. But we heard that this model has some unintended consequences especially in midwifery, including increasing demands for supervision by experienced staff and reduced job opportunities for Band 6 midwives. Increasing the number of senior roles and ensuring systematic formal support to accelerate confidence in students and newly qualified midwives will be essential to address this.

We heard from students, midwives, and educators that despite the quality of undergraduate university education (described below) students and newly qualified staff are having a particularly difficult challenge in gaining essential experience in caring for women through physiological labour and birth because of the increase in caesarean birth rates. They are also experiencing the challenge of high-profile public criticism in this work as physiological birth has become a contentious topic in social and some mainstream media. We heard that educators, students and midwives remain committed to learning this essential skill, recognising that they are the only professional group who provide this care.

A key gap in providing integrated multidisciplinary services was reported as being inadequate numbers of allied health professionals to provide, for example, physiotherapy, occupational therapy and speech therapy as well as pharmacy and psychology services. In some areas they were non-existent, in others they were under-staffed and none of the neonatal units currently meet BAPM standards[43].

Coordination of time critical pathways

There was significant variation in equitable access to dedicated consultant obstetric and senior midwifery cover for labour ward and maternity triage services. This variation was most pronounced in low-birth-rate units, where limited consultant presence and fluctuating senior midwifery capacity contributed to increased operational pressure and reduced oversight. These staffing pressures were closely linked to challenges in delivering timely, reliable, and standardised care across time critical pathways including triage, induction of labour, and both emergency and elective theatre services. Variation in these critical functions was observed across all Health Boards and frequently created bottlenecks within the maternity pathway. The resulting delays, escalation pressures, and inconsistencies in decision-making increased clinical risk and had the potential to compromise the safety and quality of care. Inadequate out of hours medical cover in smaller units, alongside competing demands on medical staff covering services such as general paediatrics and gynaecology, and on midwives expected to cover multiple responsibilities, were also described as factors affecting the quality of care in this critical area. All Health Boards are committed to implementation of the Birmingham Symptom-specific Obstetric Triage System (BSOTS)[45], but they are currently at different stages.

Staffing and resource impact of the current model of maternity care

A related factor across the workstreams was the impact of a model of maternity care that has developed rapidly in recent years in hospitals, with a focus on risk labour and birth and very high levels of induction and both planned and unplanned caesarean birth (Section 3). This was recognised by many as concentrating staffing and resources in labour and birth and away from other parts of the maternity journey including antenatal care and education and postnatal care for women and babies (Sections 4 and 5). As a result, women, parents and families described receiving care that was more fragmented across the maternity journey with less preventive and supportive care and information both before and after the birth. We heard about some examples where staffing models had been developed to mitigate this problem. No Health Boards had solved the problem of ensuring an adequate staff skill mix when labour ward and postnatal wards become busy, without reallocating staff from other areas.

Interventions in labour are essential when needed and wanted and their rapid increase, seen across the whole UK, has been seen as a response to changes in population health, increasing deprivation, and increasing complexity (Section 3). Behavioural and organisational factors influencing these changes have also been identified, including staff stress and public anxiety resulting from high profile reviews[46]. Interventions are not without their risks, and it is important for women to understand these and to evaluate their implementation and consequences[47] including long-term impact on women's health and fertility, child health and well-being, and resource use. The high intervention rates have not been reflected in improvements in outcomes or experiences; intrapartum stillbirth rates have remained static and immediate maternal outcomes have worsened (Section 3). This could be in part a result of unintended consequences of changes, including staffing and resource pressures, and more women experiencing major surgery. The recently published NHS England maternal health care bundle[48] could be a helpful resource to inform improvements in the care of women.

There is a mismatch between the current model of care and the staffing and resources available to provide it. There is limited quantitative information on staffing and appropriateness for the model of care, but what exists, and what we have heard, identifies serious problems for obstetricians, anaesthetists, and midwives. There has been little or no increase in theatre provision or labour ward staffing to match the increase in caesarean births. There is a move towards separate planned caesarean lists/staffing in a designated space but that has not yet been implemented in all Health Boards. Covering the highest acuity areas has resulted in a substantive opportunity cost for other areas, and women and partners and staff described a negative impact on staffing for postnatal care and community. Inconsistencies, delays, and cancellations of induction of labour have been reported, impacting on women's experiences and outcomes[49], like reports in other UK countries[50]. It is essential that workforce reviews and staffing models consider current needs across the whole continuum of care.

Model of neonatal care and commissioning

Neonatal service provision across Wales appears to be characterised by a clear division between the north and south regions. In North Wales, which is within a single Health Board, effective collaboration and communication was observed between units, however there was a lack of alignment with fetal medicine services. In the rest of Wales, the current configuration of neonatal services appears marked by fragmented coordination, inefficiencies in service organisation, unclear interdependencies and an interim 24-hour neonatal transport model causing a variation between in-hours and out-of-hours service provision. There are a larger number of cots than expected for this configuration. These issues have the potential to affect the consistency and overall experience of care for women, parents, babies, and families. Staff wellbeing can also be affected. Neonatal nurses reported an impact on their wellbeing in being asked to travel some distance between units at the start of a shift to cover gaps in service and neonatal consultant's report a negative impact of the continuing uncertainty over out-of-hours transport staffing.

The NHS Wales Joint Commissioning Committee (JCC) Phase 2 neonatal configuration programme represents a key opportunity to address longstanding neonatal service configuration issues and needs to be expedited. This is particularly important within South Wales Neonatal Intensive Care Units (NICUs), where capacity, sustainability, and patient flow remain persistent concerns. A coordinated national approach that includes maternity services is essential to providing equitable access to the right level of neonatal care, in the right place, at the right time, supported by appropriately resourced and sustainable staffing models.

Effective, reliable, and standardised transitional care and neonatal outreach services are central to enabling mothers and babies to remain together wherever possible and safe. Where these services are well-established, they reduce avoidable admissions, support earlier safe discharge, and ensure continuity of care across the hospital–home interface. However, inconsistent or non-standardised transitional care arrangements combined with variable outreach capacity results in transitional care often not being delivered optimally. This not only places additional pressure on maternity and neonatal services but also leads to unnecessary separation of mothers and babies and undermines family-centred care.

Compounding these operational challenges is a lack of clarity at local, Health Board, and national levels regarding the roles, responsibilities, and inter-relationships between organisations involved in maternity and neonatal care. This ambiguity limits effective oversight, constrains performance and quality monitoring, and restricts the system's ability to drive sustained improvement.

Incident reviews

Discussions with national bodies, Health Board senior teams, staff and families have highlighted that the current systems for reviewing maternity and neonatal incidents, from low harm and near miss events to moderate to major harm incidents, including perinatal mortality, are complex with unclear thresholds for local or national reportable processes.

A consistent, kind and compassionate approach to all parents in this situation is essential, but we heard that the processes for incident reviews are lengthy and confusing, and they do not receive consistent support.

With National Reportable Incidents, there is a lack of clarity on reporting thresholds, serious gaps in family involvement, an adversarial, legalistic approach and delays in processing reports due to delays in national sign-off and difficulties in securing external reviewers. Apologies may be delayed on receipt of legal advice, leaving families hurt and confused and staff hampered in engaging in discussion and support with them.

Executive teams, national bodies, clinicians and families all agree that the process for incident reporting is not yet clear and person-centred enough, despite the relatively recent introduction of cross-NHS guidance. Perinatal care has additional, complex reporting requirements, including to UK bodies such as MBRRACE-UK. A specific, accessibly written standardised operating procedure for all levels and types of reportable incidents in perinatal care, with a flowchart, would enable families and staff to more easily and transparently navigate the system. This would set clear expectations for external review, meaningful family engagement, identification of learning, and the translation of findings into demonstrable improvement.

There is an opportunity to work in collaboration with other UK countries on this. Systems including MBRRACE-UK and Perinatal Mortality Review are UK-wide, and a more standardised approach would streamline the care for families having cross-border care with England. There is potential for much more coordinated learning from incidents with, for example, a national repository for anonymised review reports, with suitable access controls to preserve privacy, and a regular national report of cross-cutting themes.

A further very positive step would be for national bodies such as the Welsh Risk Pool and NHS Wales Performance and Improvement, in collaboration with families and staff with experience of the current system, to co-produce improved guidelines based on restorative justice principles, Such an approach adds relational processes to regulatory processes and can be an important tool in preventing compounded trauma after a family has experienced harm[51].

Mental health services

The landscape for perinatal mental health provision is uneven and disjointed. Multidisciplinary perinatal mental health services for women with moderate to severe mental health conditions from pre-conception to the baby's first birthday have developed a consistent all-Wales approach since the Senedd Inquiry in 2017, and team leads report that waiting times for assessments have significantly reduced.

With 31.6% of women in Wales self-reporting a mental health condition at their initial assessment[27], and others developing needs through experiences such as miscarriage and birth trauma, the specialist perinatal mental health teams cannot meet all demand. There are significant gaps in perinatal mental health support for women and family members that do not meet thresholds for perinatal mental health specialist teams, and in training and support on responding to trauma for all perinatal staff. Only two Health Boards have a psychologist providing services in their maternity units. Fifty percent of the Health Boards do not have any neonatal psychology support, indicating that Wales does not meet the British Association of Perinatal Medicine quality standards on psychology staffing[43].

In this, Wales lags behind services in Scotland and England, where there are comprehensive clinical pathways in perinatal care for meeting mental health needs from lower level to severe conditions. Not all mental health needs could or should be met within maternity and neonatal units. But clearer all-Wales clinical pathways would enable clearer expectations of Health Boards and support a more equitable approach across Wales. There is a health economics case for improving mental health service provision, alongside the evident human needs at stake here.

Breastfeeding care and services

Despite policy support[2] for implementation of the UNICEF UK Baby Friendly Initiative (BFI) standards[20], it is clear from the findings in Sections 3 and 4 that problems in receiving consistent care and support for breastfeeding persists. Progress on BFI accreditation has slowed in maternity and neonatal units. The same is true in several universities, meaning that newly qualified midwives and health visitors may not have the knowledge and skills needed at the start of their careers. We heard that implementation of these standards has been a low priority in recent years, with no national resource to support the policy and variable support from Health Boards.

Optimising the contribution of consultant midwives

We heard that the role of the consultant midwife is highly valued and central to many service pathways. Consultant midwives were described as supporting decision-making, contributing to personalised birth planning, reviewing complex cases, and providing specialist input for women with previous caesarean births or 'out-of-guidance' referrals to midwifery-led units. Their involvement promotes consistent professional oversight and alignment with best practice. Nevertheless, consultant midwife contributions vary between sites, and some services described limited or unclear integration with the multidisciplinary team.

Staffing and pathways for midwifery led units

Wales has 11 standalone and nine alongside midwifery-led units. In general, these are well supported by the Health Boards and women described very positive experiences. Staffing instability, most notably the redeployment of midwives away from birth centres, continues to reduce access to midwifery-led care however, and limit women's birth options. Inconsistent pathways, particularly around birth options and requests for care outside of local guidance, contribute to variation in women's experience and increased staff anxiety. Escalation and transfer processes were well understood and generally described as timely.

Individualised, 'out of guidance' maternity care

The current model of care may contribute to the increase in requests for 'out of guidance' births. Care outside of guidance was consistently reported to be increasing. We heard of a split amongst the staff, with some feeling supported and empowered to support women with counselling, planning and attending births, while others described feeling challenged, not supported by senior staff and anxious from a professional perspective.

Being able to provide individualised care across the whole continuum of care is important in enabling women's decisions and to ensure women are supported throughout their maternity journey, and it is essential that the staff caring for them are experienced and supported by the multidisciplinary team[52, 53, 54]. We heard however that 'out of guidance' care can be a serious challenge for the staff, usually midwives, who care for them in community settings, with potential for Morale injury and professional vulnerability if there are adverse outcomes. Staff described it as most difficult where there is no continuity of care, and where adversarial situations develop. They also identified the need for accurate accessible digital content to counter misinformation. Consultant midwives were described as supportive for care 'out of guidance', and they are currently developing an all-Wales document to support community midwives when this is requested.

Specialist roles

We heard from midwives, neonatal nurses and from Health Board self-assessment that specialist roles for midwives and neonatal nurses are a positive move, responding to population need, supporting multidisciplinary clinical staff, and enhancing women's and babies' care. These include roles in infant feeding, bereavement, and safeguarding, for example. There is inconsistent implementation across Health Boards however, and these roles are not securely funded, compromising their ability to contribute to long-term sustainable change. Some tension was described; because their clinical roles were not always replaced, in some instances they were experienced as a loss to the core clinical team. Staff also expressed concern that these colleagues may lose clinical skills in other areas over time, and that it is important for these roles to support and develop staff in these areas. Greater transparency and consistency would help to maximise the potential of these roles.

Cross-cutting theme 4: Enabling environment, psychological safety for all staff and students

Strengths

On site visits and during staff engagement, lots of mutual support between staff was observed and reported. Staff across all groups reported that a lot of goodwill was needed to keep things going. They described strong peer support, professionalism, and a deep commitment to the safety of women and babies and to quality care. A warm, welcoming atmosphere was encountered on most site visits. Smaller units demonstrated more of a sense of team and mutual support. The atmosphere in midwifery-led units was especially valued.

We saw areas where the environment was very positive; these had accessible leadership and multidisciplinary working including joint rest areas and regular safety huddles. Staff reported having better conversations and increased trust with continuity of care and with established multidisciplinary teams. We did not see evidence of a widespread blame culture which has been identified in previous reports.

Across all workstreams, staff described a perinatal workforce that is committed, resilient, and values women, baby, and family-centred care, yet is constrained by structural, cultural, and environmental pressures. This aligns with the findings in previous reports (Section 3). The consistency of these accounts across Wales provides a clear picture of current conditions, the pressures affecting quality and safety and the strategies staff believe are helping services to cope. Staff also identified patterns of variation and practical opportunities and described these as likely to support workforce wellbeing, service sustainability and the lived experience of women and families if they were addressed.

Women and families were generous in their awareness of staff pressures and the constraints they worked under.

Areas for improvement

Work culture

Senior leaders in Health Boards felt there was a positive culture that enabled staff to speak up, with a culture of empowerment and visible leaders. While there were examples of this, this assessment was at odds with evidence from other workstreams. We heard of examples of a disrespectful and undermining culture (Section 5 and 6). We heard some poor results in feedback from the GMC, RCOG and from students and resident doctors about staff not feeling safe to speak up in a consistent manner. Several staff talked about lack of time for learning and improvement, all demonstrating that there is more work to be done to enable staff consistently to engage pro-actively in a learning, improvement culture.

We heard in Section 7 that board interest and ownership was fundamental to improving culture. It was clear that in past years teams had felt unheard and isolated from boards, but more recent years have seen a shift and some staff reported that better board oversight and engagement meant their key risks and voices were being heard more effectively.

Staff wellbeing and support

There were clear indications throughout our work of high levels of staff stress, anxiety, and sick leave but we saw inconsistent response to this within the Health Boards. In Section 3 we saw that the most common reason for staff in perinatal services to be on sick leave is due to anxiety, stress, depression and other psychiatric illnesses. This problem is not recent but has been recognised for some years, and a more pro-active approach to staffing levels and support is needed. All Health Boards reported that they have well-being services that are accessible to all staff, but we found that not all staff were aware of these, and these services cannot successfully minimise staff feeling that time off work is the only solution to their stress and ill health. There was a lack of action and expectation both at national and Health Board level for staff well-being and on the provision of psychology services to support staff following difficult incidents.

Professional leadership

We heard that better alignment is needed between strategic and clinical leadership, to rebuild trust, tackle retention, and to foster a climate of learning, not reaction. Consultant midwives and clinical leaders were consistently identified as credible and supportive, and trusted advocates for evidence-based practice and quality improvement. Advanced Neonatal Nurse Practitioners (ANNPs) were described as improving the relationship with maternity and improving safety and quality. Staff reported higher Moralee and psychological safety when they were there. Supernumerary senior coordinators were identified as a positive strategy that would help in both midwifery and neonatal services and ensuring obstetric expertise.

Although staffing bands are not directly comparable between neonatal nursing and midwifery – ANNPs are senior roles but are focussed on providing clinical care - there appear to be relatively few midwives appointed at Band 8 and 9 (Section 3), and we heard from other workstreams that additional clinically-involved senior leadership in midwifery would help in addressing the current skill mix challenge. In some sites senior staff are not supporting practice even in times of crisis, though we also heard good examples where this happens. The recent appointment of Directors of Midwifery is a positive step, but this talent and leadership shift is not realising its potential. We heard of a lack of clarity in the relationship of this role with the Head of Midwifery; alignment and development of these roles is essential. As perinatal teams evolve, this clarity in purpose and alignment of roles in a collaborative and supportive manner will be essential for the collective success given the scale of work.

Equipment and estates

We saw in our site visits and from staff that aging and inappropriate estates are having an impact on culture, quality of care, and staff wellbeing. Both equipment and the buildings are a concern, they are inadequate for the model of care and cause hazards that affect staff on an everyday basis. These issues are described in more detail below.

Cross-cutting theme 5: Whole-system support for universal, whole-continuum, accountable, knowledgeable, skilled, kind midwifery

Strengths

Except for a small minority, women, partners and families described having much more contact with midwives than with obstetricians. We heard very positive family feedback about midwifery, and they would welcome more midwifery support, especially for postnatal care.

Midwifery-led care in both freestanding and alongside units was consistently described across the workstreams as delivering compassionate, kind, personalised and relationship-centred maternity care, described above.

We heard very positive reports of midwifery education in the four universities in Wales providing undergraduate midwifery education. All four received high scores in the most recent National Student Survey, placing them in the top ten programmes in the UK for student satisfaction. Application numbers are high, with several applicants for every place. The Lead Midwives for Education meet regularly together to discuss and address challenges, and we heard of strong alignment between university and practice environments.

The strengths identified in midwifery services in Wales and the support from women and families, multidisciplinary colleagues, and national organisations, demonstrate an important national opportunity for Wales to strengthen and build on its midwifery services.

Areas for improvement

Safety and quality of midwifery care and education

The safety and strength of maternity services depend on a strong midwifery service to provide quality care for all women and babies in hospital and community, across the whole continuum of care. Midwives are the only professionals who provide universal care for all women, babies, partners/parents and families in all settings, including prevention, support, information and relationship-based care. In addition to their clinical role, midwives have the responsibility of advocating for all women regardless of their background or circumstances, in line with their professional standards. We heard of constraints on their time to provide this care however, and women talked about the impact of that, including their need for more antenatal care and education, more discussion and information, and more postnatal care.

Across all the workstreams there were indications of the serious challenges experienced by midwives, midwifery educators, and students. Staffing constraints, stress, anxiety, and high levels of sick leave have been described above. Very high levels of distress and burnout have been described over many years, and a recent survey of UK midwives by the Royal College of Midwives 2025 found 45% of midwives reported feeling burnt out ‘often’ or ‘always’.

We heard that the task-focussed care that has developed, and the rapid increase in intervention rates, have had a major impact on the work of midwives and on the quality and scope of care they can provide. We heard that they are frequently pulled away from antenatal and postnatal care, and even community and midwifery-led units. There were good examples of Health Boards developing staffing models to prevent this, but these were not consistent. Students and newly qualified midwives are struggling to gain the experience they need in caring for women through physiological labour and birth as numbers of women having physiological birth has fallen rapidly in recent years.

Women also described wanting to have more continuity of midwifery carer. Despite the strong evidence base[55] that demonstrates impact on outcomes and experiences for all, especially for women and families with complex additional needs[41], and some good examples of Health Boards working towards implementing this form of care, we did not observe consistent work towards the system-level shift required to implement this form of care as standard. Midwives cannot implement it without whole-system support, as it requires different ways of working and support and education to work in a very different way.

We heard from site visits, staff engagement, clinical and board meetings, and Lead Midwives for Education that midwives' role is being stigmatised, with public hostility. They described being adversely affected by the UK-wide public criticism of midwives in social and mainstream media over the past few years. Much of this criticism has been around what has been termed 'normal birth ideology' in UK media. We saw no evidence of this ideology in any workstream. Our respondents described a 'hostile environment' that was demoralising and some midwives told us that they no longer feel safe to say they are a midwife in social circumstances. They told us that the quality of midwifery education has been criticised despite regulation both by universities and by the professional regulator, the Nursing and Midwifery Council, which has strong evidence-based professional standards. This hostility has raised questions about the sustainability of the profession and the future workforce. Midwives, educators and students need pro-active support at this challenging time to prevent long-term harm to the profession, and critical damage to the safety and quality of care.

Cross-cutting theme 6: Structures, processes, and resources to assure whole continuum, evidence-based, planning, monitoring, governance and commissioning

Strengths

We saw clear evidence that Health Boards have increasingly recognised the importance of focussing on maternity and neonatal services in the last three years, because of the Maternity and Neonatal Safety Support programme[1] which is now in the implementation stage.

We heard from staff that a key factor in this development was the fact they now had board members and board oversight that meant their key risks and voices were being heard more effectively.

At an individual team and local level there were some good examples of a positive culture where teams were working collaboratively across disciplines and with leaders.

We found no defensiveness in Health Boards. They talked openly about risks and how to address them, they were positive about working across Health Boards, recognising the need to collaborate.

Areas for improvement

National structures

In our workstreams we have noted that the national organisations tasked with monitoring, seeking accountability, commissioning, inspecting and driving improvement were largely working in parallel rather than maximising the potential of sharing intelligence and agreeing priorities. Remits and responsibilities were not well-defined, particularly in relation to the National Strategic Clinical Network for Maternity and Neonatal Services and functions of NHS Wales Performance and Improvement. There is no publicly available guide to how national organisations work to ensure safety and quality, therefore it is not clear whether there is overlap of responsibilities or gaps in accountability. Neither Health Boards not national organisations themselves found it easy to describe this national governance landscape in perinatal care.

Senior coordinated national leadership

The national leadership for maternity and neonatal services across government, national organisations, and Health Boards is not appropriately multidisciplinary. Informed multidisciplinary leadership is needed at every level. There are examples of joint multidisciplinary teams at a national level in other UK countries.

We did not encounter a strong culture of curiosity that valued diversity of thinking and empowered colleagues to flourish among senior leaders collaborating across the networks and nationally.

We saw no evidence of mechanisms to involve women and families in defining national policy, strategy, or planning services to reduce inequalities and inform the future provision of care. There is no public access to timely data on perinatal services, experiences, processes, and outcomes. There are no clear public explanations of the roles of different organisations and how they relate to each other.

Health Board functioning

Overall, governance and reporting structures had been significantly strengthened across all Health Boards regarding perinatal services in the least the last two years. However, there is still a significant amount of work needed to strengthen these further.

We saw signs of apparent inertia while awaiting national developments, and a lack of pace despite their recognition of what was needed. Self-assessment scores did not match evidence in many areas. Some key areas of safety are not being addressed including triage and the extent of staff stress. There are gaps in accountability, and a lack of timely decision-making

A more systematic approach to reviewing holistic qualitative and quantitative intelligence related to culture and staff well-being was needed in some Health Boards. We did not observe a consistent culture of taking a strategic overview of a number of metrics to provide a more holistic picture of risks and outcomes across perinatal services. It was not evident how those outcomes were used to inform national and local priorities in the planning cycle. When this strategic approach was discussed with senior leaders, there was no consistent view of any national drivers or associated national People Plan to underpin the Health Boards' work in this area.

When we explored how Health Boards were measuring the impact of initiatives on outcomes and access, they recognised this was an area that needed further development and focus. Directors of Public Health are uniquely placed to advise each Health Board on inequalities in their local community. Further consistent work is needed to use this knowledge in a more intentional and targeted manner to reduce inequalities and improve perinatal outcomes.

Some boards were not visiting the clinical areas and were delegating this to executives. In some boards, there too many layers of governance between the board and the clinical areas, with unclear accountability. Obstetrics was described as very stretched and there were few signs that obstetricians were involved in governance.

Quality improvement methodology was not embedded into daily practice and there was not a clear improvement framework known by staff across all teams within Health Boards.

Data and monitoring

The data we collated for this assurance assessment required extensive support from data analysts and had not been collated in this form before. All items were essential to have an overview of maternity and neonatal care, services, health and wellbeing. It is not clear to us how national and board-level decision-making can be informed and accountable in the absence of consistent, complete and timely data. Information submitted to us by Health Boards was presented in inconsistent ways and was not directly comparable. Monitoring and assurance at both board and national levels requires consistent collection and presentation of data. Data are an essential tool to monitor and review equity and ongoing analysis of inequalities, especially by deprivation and ethnicity, is essential.

The implementation of BadgerNet® Maternity will help with this to some extent. It is not yet nationally implemented however and there will be implications for staff and service while it is implemented that may impact data quality and staff time.

Monitoring requires both quantitative and qualitative data, and we found inadequate information on the experiences of women and partners/parents to inform our work, or ongoing monitoring by health boards and national organisations. Improvements are already in hand; it is important to conduct a large-scale survey of views and experiences, on a regular basis so that trends can be monitored and ensuring the inclusion of women and families from diverse backgrounds.

The availability of accurate data is one challenge; access by all people and organisations from relevant sectors is another. We saw no evidence that staff providing services, or the public, have access timely data on services and outcomes, in contrast with other UK countries.

Estates and equipment

Significant issues with estates and equipment were evident across several workstreams. In some sites, the condition of the estate was directly impacting staff wellbeing, organisational culture and the quality of care provided.

Facilities and equipment were often inadequate to support the current and planned models of care. Older buildings frequently had limited capacity for storage, resulting in cluttered corridors and equipment being stored in public areas. Signage was often unclear, and access arrangements were confusing for families and visitors. While some estates were reported to be very old and in poor condition, there were examples where adaptation was possible. For instance, having maternity and neonatal wards in proximity supported safer clinical working and better communication

High bed occupancy, with more women needing admission than existing capacity could comfortably support, was reported in some units. Small labour rooms and undersized theatres compounded these pressures, resulting in the use of workarounds that increased operational risk and staff workload.

In several settings, dedicated spaces such as family rooms or specialist areas, had been developed through charitable funding rather than through core capital investment. While this demonstrated commitment and creativity, it also highlighted inequities and a reliance on external funding to meet basic service needs. Bereavement facilities were variable. In some areas, issues included poor soundproofing, limited availability and lack of privacy. However, staff frequently showed initiative by repurposing existing spaces to create bereavement rooms or parent accommodation within neonatal units, despite constraints. Estates limitations were particularly restrictive for the delivery of Family Integrated Care in neonatal units. The physical environment often did not support parents to stay overnight with their babies or participate fully in care.

Finally, outdated IT systems and limited interoperability continued to impact communication, data entry and the effective use of information for planning and monitoring.

Commissioning

We heard that the current commissioning model for maternity services is through a block contract with Health Boards. There are no measurable standards or outcomes linked to this funding. As a result, the levers to promote change are limited.

We saw no evidence of strategic, outcome-focussed commissioning which would underpin a significant whole-system shift towards safe, quality care for all. Detailed, evidence-based, national standards for maternity and neonatal care and services would be needed to inform this. Scotland is currently finalising such standards, having recently completed public consultation[56].

Cross-cutting theme 7: Political will, evidence-informed policy directions for safe, equitable, quality maternal and newborn system, with ongoing commitment

Strengths

There are clear indications of political support for maternal and neonatal care in Wales, not least in the commissioning of this assurance assessment and the strong support we have received throughout.

There are a range of positive policy documents across this area and related fields, including:

- The Maternity Strategy, Maternity care in Wales: a 5-year vision for the future (2019-2024)[57], which outlines five key principles: family centred care, safe and effective care, continuity of carer, skilled multi-professional teams, and sustainable quality services
- The Quality Statement for Maternity and Neonatal Services[2] describe what services should look like and includes 12 health and care structured under six domains of quality: safe, timely, effective, efficient, equitable and person-centred, supported by six quality enablers: leadership, workforce, culture, information, learning, improvement and research, and a whole systems approach

Related documents include:

- Improving Together for Wales, the Discovery Phase Report for the Maternity Neonatal Safety Support Programme Cymru[1]
- The wider plan for health and social care; A Healthier Wales: our Plan for Health and Social Care[58] which includes an ambition to provide support and prevention as well as treatment
- The National Clinical Framework[59], which outlines the ambition for a learning health and care system
- Quality Statement for Women and Girls' Health[60] and the Healthy Child Wales Programm[61] are important additional sources
- The Mental Health and Wellbeing Strategy 2025-2035[62]

Realising the potential of these key policy directions by ensuring that they integrate effectively with each other and by funding and implementing effective actions is essential to improve safety, health and well-being for all.

Areas for improvement

We saw clear signs of strength and excellence across the services and heard of plans already developed to address many of the problems we identified. There was, however, a lack of recognition of the urgency of the situation and the level of resources needed to implement the changes needed in regard both to the safety of women, babies and families, and the health and well-being of staff.

We saw and heard that the Maternity and Neonatal Safety Support programme[1] (MatNeoSSP) has influenced a positive shift towards integrated perinatal services. Health Boards told us however that the programme was not gaining the traction it needs, in part because of insecure funding and staff being on short term contracts. As the main vehicle for improving perinatal care and services, it needs a secure funding base to plan and implement long-term work.

Responding to reviews and reports

Our review of over 500 recommendations from previous reports (Section 3) found that many were responding to similar problems. Some respondents noted that the issues described in the Cwm Taf[63] and the Swansea Bay reports[64] are seen across Wales, but implementing change has been slow and evaluation of outcomes is an issue. Our work has identified many of the same issues, demonstrating that widespread change has not yet been implemented. This suggests that there are barriers to the implementation of large-scale sustainable change, and perhaps that maternity and neonatal services do not yet have the priority needed for large scale sustainable change in Wales.

Large scale sustainable evidence-based change

The challenges we have identified require sustained investment at a level that reflects the critical importance of maternity and neonatal services to all women, babies, partners and parents, families, communities, and to long-term population health. These services provide a foundation for lifelong health and well-being. Economic analysis of changes should include the potential for this long-term impact as well as the short-term improvements for women and babies. Public engagement and cross-party political support are needed to invest in what is likely to be a 10-year programme of system transformation.

This will require

- a planned, evidence-based, national implementation and monitoring framework
- a change programme informed by evidence of what works in creating large scale sustainable change, including building on strength as well as learning from failures, and engaging the public and multidisciplinary staff in designing and implementing change[65, 66, 67].

Section 9: Recommendations

This section lays out and provides a brief rationale for our recommendations based on the evidence from this assurance assessment. As a panel, we are keenly aware that too many, highly detailed recommendations can serve to slow down meaningful change, as bodies tasked to respond to them draw up detailed spreadsheets and working groups. They risk becoming overwhelmed or embroiled in detail and unable to prioritise actions that will create change that will be seen and experienced by women, parents/partners, families and staff.

The Welsh perinatal system has received over 550 recommendations from reviews, inquiries and inspections in the last decade. It is unsurprising that many of our conclusions and recommendations mirror closely the national recommendations from The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board[64] and the Maternity and Neonatal Safety Support Programme Discovery Phase Report[1].

We have identified priority areas where change is both required and possible and have identified a small number of actions required under each of these. They are interdependent and action on an individual recommendation in isolation is likely to be ineffective. For that reason, they are not ranked in order of importance.

These recommendations are intended to remove the uneven delivery of care across Wales which can result in a postcode lottery of quality and experience. Some will require additional investment, while others may be achieved within current resources. They will need to be operationalised in an inclusive and co-designed way with women, parents, families, communities and staff. It is important that all care and services, and all changes, consider and aim to reduce inequalities in experience and outcomes, particularly those related to socioeconomic status and ethnicity.

Clear and co-ordinated national leadership will be needed to set out specific and measurable national expectations, to facilitate benchmarking within a systemic improvement framework. We have set out below our thoughts on how this can be achieved.

1

Joined up national perinatal leadership

2

Universal offer of high quality care

3

Urgent attention to critical clinical safety systems

4

Enough staff and the right spaces to care safely

5

Support for mental health and wellbeing

6

Improved planning and commissioning for neonatal care

7

Learning from reviews with families involved

8

Listening, understanding and improving through real feedback

1: What is needed?

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

As described in section 8, our panel identified a lack of clarity within national governance structures, with a degree of reliance on good working relationships and informal intelligence-sharing. This is despite recent improvements following the launch of the Maternity and Neonatal Safety Support Programme[1] and the introduction of the Welsh Government's quarterly 'deep dive' IQPD discussions on perinatal services with each Health Board.

There is not a comprehensive, joined up approach to oversight of perinatal services to monitor data, advise the Welsh Government on priority setting and drive forward improvements. National governance structures are widely seen and experienced as disjointed and unclear.

While a Chief Midwifery Officer is in place in Welsh Government in common with other UK nations, there is no national clinical lead role for obstetrics, neonatology and obstetric anaesthetics. NHS England has national clinical director roles in obstetrics and neonatology to provide coordinated multidisciplinary leadership and oversight.

There are no national mechanisms for hearing from users of perinatal services or from staff, students and trainees delivering services. We believe this is a missed opportunity to co-create and evaluate the success of service developments.

Overall, we believe that a much-strengthened collective national oversight of perinatal services is needed, with the requisite authority and comprehensive understanding to drive continual improvement and nationally consistent standards of care and safety.

We recommend:

a. A national perinatal team

There is currently a FTE (full-time equivalent) Chief Midwifery Officer in Welsh Government. We recommend that national Clinical Directors or leads in obstetrics, neonatology, neonatal nursing and obstetric anaesthetics are appointed at varying levels of FTE. This will establish a multidisciplinary national perinatal senior clinical team to work together with the Chief Midwifery Officer to advise on and drive policy developments in the Welsh Government and hold Health Boards and other service-providers to account.

In addition, broader oversight is required at a national level to drive and oversee change. We therefore recommend:

i) A national strategic oversight board.

This board should include all relevant national stakeholders with a remit for perinatal services (including but not limited to HIW, HEIW and the WRP), the national perinatal team and a service user representative. The aim of this group would be to achieve comprehensive oversight and shared accountability. This group should meet regularly to:

- provide a single, coordinated mechanism for monitoring and acting upon multiple sources, including qualitative data, Regulation 28 reports, incident data, MBRRACE-UK and NNAP findings, experience measures, Beacon dashboard clinical metrics, public health data, workforce and national benchmarking data.
- identify and advise the Welsh Government on policy and practice gaps, including national service specifications and strategic workforce developments.
- Identify which groups are more likely to experience poorer outcomes than others and ensure that action is being taken to address this.
- Identify good practice and promising initiatives and consider how they may be evaluated and shared nationally.
- facilitate the development of a co-produced National Framework for Improvement in Perinatal Services, linked to the Quality Statement Maternity and Neonatal Services[2] and the priorities identified in this report.
- scrutinise the delivery of improvement programmes, using the National Framework for Improvement. This will require the Board to establish and receive reports from workstreams involving boards and national bodies to ensure timely and nationally- consistent implementation of changes in areas such as workforce modelling, critical clinical safety systems and continuity of care. The Board will need to be responsible for ensuring that all programmes of work are fully integrated into the whole continuum of care.

Clear Terms of Reference for this board should be agreed and published so that there is transparency about this board's remit and accountability.

This board should have two specialist sub-committees: the first to frequently monitor and act on quality and critical safety signals data and the second to oversee Health Boards' operational delivery of the perinatal National Reportable Incident process, and to ensure that learning from them is collated and disseminated.

The engagement and insights provided by a broad sector partnership is necessary for developing a shared national understanding of service gaps and inconsistencies and developing solutions. Therefore, we recommend:

ii) A national women, parents and communities maternity and neonatal group.

We have been informed that there is a current plan for a National Maternity and Neonatal Voices Panel[38] which would have as its membership the paid Chairperson of the Maternity and Neonatal Voices Panel from each Health Board. We recommend that this national group also includes representatives from community advocacy groups representing populations known to be at increased risk of poorer experiences and outcomes in perinatal services. It should elect a representative to sit on the national strategic oversight board, described above.

iii) A perinatal stakeholder group.

Our assurance assessment panel has been advised by a wider stakeholder group including the voluntary sector, advocacy representatives, UK bodies such as the NMC and the GMC and representatives of different staff groups, including allied health professionals. Their advice and challenge have proved invaluable, and we recommend that it is retained to meet quarterly and to have Terms of Reference that enable the views of the group to inform the national strategic oversight board. Its current membership should be reviewed, and we suggest it is expanded to include educators, researchers and student representatives.

We also recommend that once a year the national perinatal team convenes with the oversight board, the National Women, Parents and Communities Maternity and Neonatal Group and the Perinatal Stakeholder Group for an in-person, collaborative event. This event should support the collective agreement of priority areas for improvement, establish approaches for delivering change, and review progress against actions from the previous year. Participation should extend beyond these groups to include women, parents and families, staff across all roles, students, trainees, educators, voluntary sector representatives, national bodies, and executive teams. Established co-production methodologies should be used to ensure all participants have a genuine opportunity to contribute to perinatal service development. Co-producing change in this way will support improved shared understanding, more effective solutions, stronger implementation, and greater accountability.

b. Data and monitoring

There is a clear need for more systematic, joined-up monitoring of comprehensive data sets at a national level, with real-time monitoring of critical safety indicators. As described, a national oversight group should be responsible for this. To enable this, the development and implementation of the national Beacon dashboard should be urgently prioritised and its use to drive whole-system understanding and improvements implemented. This data should be made publicly available in regular reports.

The Welsh Government should additionally, and at pace, implement an additional safety signals dashboard, such as the MOSS[68] dashboard recently implemented in England, to enable real-time monitoring of key safety indicators across maternity and neonatal services in Wales, and swift intervention as required. This should be monitored by a subgroup of the national oversight group and include requisite clinical and academic expertise.

c. National governance

As described in section 8, the panel found it difficult to understand how the national bodies tasked with monitoring quality and safety, facilitating continual learning and improvement, ensuring accountability, and inspecting services, relate to each other, to Health Boards and to other service providers. It is imperative that there is clear and accessible information to enable the public and staff to understand this complex landscape of governance. We recommend that an accessible map and explanation is published within six months of the publication of this report.

2: What is needed?

A universal offer of quality care throughout the perinatal journey

All our recommendations aim to improve the care and safety of perinatal services. We are clear that perinatal safety and quality begin at pre-conception and continues through antenatal care, intrapartum, postnatally and into infancy.

While we necessarily direct our recommendations to health services, we note that services such as Flying Start[10], and voluntary sector community groups, play a key role in providing group and individual support and advice.

Continuity of care: Research and evidence we have heard from women, parents, families and staff in this assessment supports continuity of care by midwives and, where required obstetricians, to ensure relationship-building, trust and meaningful decision-making. Continuity of care includes antenatal and post-natal care.

We recommend:

- that the current rates of continuity of care by midwives is assessed in 2026-7, utilising the newly digitalised individual maternity health record; and a meaningful plan developed to increase continuity of care co-produced between the Welsh Government, Health Education and Improvement Wales, Health Boards, staff and women and families. Women with more complex social and health needs should be prioritised for continuity of care in the first stages of implementation. We are making this recommendation with an awareness that midwives being asked to work in new ways may need education and support to do this and for changes to be introduced at a pace to enable this to ensure a sustainable system

Critical safety pathways before during and soon after birth:

Delivery before and during labour may need to be expedited urgently. Some care pathways are time limited to support safe care, such as triage assessment, induction of labour and obstetric operative interventions. We have included recommendations below on implementing national service specifications regarding triage assessment and induction of labour. We also make a recommendation on adequate theatre capacity and the monitoring of real-time critical safety data.

Postnatal care:

In Section 8 we summarise our observations across all workstreams that postnatal care is being compromised as staff are frequently required at short notice to support induction, labour and caesarean births. Recommendations for the revision of staffing levels to reflect the current model of care and levels of acuity are set out in Priority 4. The provision of adequate postnatal care for all women and babies and including the post-surgical care of women following caesarean birth, must be a core component of workforce planning and staffing calculations.

- Women, parents and staff report that breastfeeding support can be compromised at this stage of care. The UNICEF UK Baby Friendly Initiative[20] provides an evidence-based framework to protect, promote and support breastfeeding, responsive feeding and positive parent–infant relationships across maternity, neonatal, community and education settings. While further implementation of the Baby Friendly Initiative is identified as a future action within the Maternity and Neonatal Safety Support Programme[1], we recommend that the Welsh Government requires all maternity, neonatal and relevant education providers to actively progress through the stages of UNICEF UK Baby Friendly Initiative[20] accreditation.
- Women should have the opportunity to understand what happened during their labour and birth, and have any questions answered. Health Boards should ensure that a birth discussion takes place with a suitable member of the multidisciplinary team involved in their care, before discharge from maternity services. Where applicable neonatal services should be involved in these discussions. This should be routinely offered, in addition to the valuable Birth Reflections service which may take place several weeks after a birth, when requested.
- Many staff and senior leaders have expressed concern about health misinformation and feel at a disadvantage when it comes to social media messaging. Welsh Government should support Health Boards to provide clear, accessible and accurate information to the public by providing templates for social media campaigns that can be adapted at a regional level.

3: What is needed?

Urgent attention to critical clinical safety systems

In section 8 we identified the need for urgent attention to triage and induction. These are time and safety-critical areas of care yet are delivered unevenly across Wales, compromising quality and safety. They require clear models for staffing and operational practices.

We therefore recommend:

Triage:

Welsh Government should move forward at pace in 2026 to commission and implement the planned national triage line. It should also publish a standardised service model for in-person triage with consistent terminology, ensuring 24/7 availability supported by dedicated staff and reliable senior clinical presence. In-person triage services should not include scheduled antenatal or postnatal assessments. We note that while not all women who access these services are clinically urgent, they are all likely to be stressed and anxious. We heard that this service is not currently adequately staffed and therefore not always consistently equipped to provide kind, supportive person-centred care; this must be a requirement of this whole provision of non-scheduled care.

Induction of labour:

A clear national service specification is required to ensure that Health Boards align with current, evidence-based guidance on informed decision making, care planning and timely access to care. The service specification should also publish a standardised service model to deliver induction of labour which describes the admission pathway, place of care, dedicated workforce and discussion of induction of labour capacity and flow in daily perinatal 'huddles' (multidisciplinary discussions).

4: What is needed?

Adequate staffing and estates to deliver safe and quality care

Throughout this report we have noted the significant pressures felt by staff due to staffing levels and skill mix not meeting the complexity of care needs in the population, high sickness levels and the rapidly changing model of care. This impacts on the quality of care experienced by women, parents and babies, and the mental health and well-being of staff. Allied health professionals, psychology and pharmacy staffing levels are low and in some cases absent. Staffing levels and skill mix were the most common concerns identified in our staff engagement sessions, site visits and desktop analysis of available data.

The British Association of Perinatal Medicine (BAPM)[43] provide frameworks to support a multidisciplinary workforce model and sets clear standards for staffing of neonatal units. In maternity services the current mandated model in Wales, Birthrate Plus®, provides workforce modelling for overall midwifery workforce numbers, which is completed three-yearly, alongside an acuity tool for midwifery staffing levels on labour ward. It does not reflect the contemporary model of care, nor the changes in complexity of physical and mental health needs, and social needs present in the population; although it is acknowledged that work is ongoing by Birthrate Plus® Cymru to review these issues. Currently, there is not a workforce tool specifically for obstetrics or anaesthetics. A multidisciplinary workforce modelling tool for maternity services is not yet in place in any UK nation, but work has begun in Wales on examining options for this. This work now needs to be developed at pace.

Even working at pace, this national workforce model development for maternity care will take time to develop. We therefore include in our recommendations the need for Health Boards to review their staffing levels as a priority, listening to staff feedback and incorporating data about levels and reasons for staff absence.

The care of women with additional and often complex health needs, needs to be consistent and evidence based. A clear need for a Maternal Medicine Clinical Network was identified by the Maternity and Neonatal Safety Support Programme[1] Discovery Report in 2023 and a proposal for its commissioning was developed by the National Strategic Clinical Network for Maternity and Neonatal Services in 2025. This now needs to be commissioned.

The condition and capacity of estates and equipment compromise safe and effective care and impacts on staff well-being. Many issues regarding aging and cramped buildings are broader than perinatal services but a clear need for adequate theatres to meet rising caesarean birth levels has been identified.

We recommend:

a. Concerted attention to current and future staffing needs.

At a national level, there should be the development and implementation of a workforce planning tool for a multidisciplinary workforce model for maternity services to mirror and integrate with the BAPM standards for neonatal services[43]. This should include adequate levels of allied health professionals, psychology and pharmacy, and should replace the current mandatory use of Birthrate Plus®. It should also include all maternity services including antenatal, postnatal and midwifery care and services for women with additional social and cultural needs.

This should be suitable for Wales's rurality and population profile and meet current staffing shortages. There may be an advantage in working alongside other UK Governments, as well as relevant Royal Colleges.

All reviews of staffing should be co-produced with staff, supported by HEIW and include women, parents and families' feedback. Time for clinical supervision, service development, quality improvement, leadership, education and training must be included.

Health Boards must address immediate staffing pressures while national workforce specifications for maternity services are redeveloped.

- Health Boards should undertake a detailed review of their obstetric workforce provision in relation to service capacity and the needs of women and families, as an integral component of their perinatal workforce planning. This review must take account of the complexity of current and future service provision, including interdependencies with gynaecological services, geographical constraints, and the challenges associated with recruitment, retention and long-term workforce sustainability.
- Each Health Board should review the sufficiency of their allied health professionals and psychologists in maternity services in collaboration with staff, women and families, ensure alignment with BAPM standards in neonatal services[43] and develop clear implementation plans to address gaps in provision.
- Health Boards should review current staffing levels and skill mix of midwives and neonatal nurses and take action to ensure that, at a minimum they are meeting current Welsh Government guidance for the use of Birthrate Plus® in Wales and BAPM standards for neonatal nursing, within the context of each Health Board's current levels of staff absence. The use of time-limited contracts for specialist roles and the subsequent effect on their longer-term impact and effectiveness should be reviewed.

b. A maternal medicine clinical network

This should be commissioned by the NHS Wales Joint Commissioning Committee. Alongside this work, NHS P&I should facilitate the review of clinical pathways for rare but serious pregnancy-related conditions such as placenta accreta spectrum, to ensure that there are clear, consistent and commissioned routes for expert assessment and treatment, within Wales or from clinicians based in other UK nations.

c. Adequate theatre estate and capacity

Each Health Board should review their theatre estate and capacity, reflecting current and future need. This should incorporate a plan for adequate theatre staffing (medical and non-medical) and that maternity theatres are appropriately located and equipped within the maternity and neonatal service footprint to enable timely support for the multidisciplinary team caring for women and babies during planned and unplanned surgery.

5: What is needed?

Mental health support

Throughout this assessment we have identified unmet mental health needs for women, parents and staff in maternity and neonatal units. Perinatal mental health provision for women with moderate to severe mental health needs has moved forward in recent years in terms of consistency of provision across Wales and clear service specifications.

Gaps include meeting lower to moderate mental health needs, therapy and counselling and perinatal mental health services for fathers. Psychology and wider mental health provision in maternity and neonatal units is available in only a small number of units, and this is not planned in parallel with existing perinatal services or more general community mental health services.

As is evident from the workforce absence data and through our discussions with staff wellbeing needs are not being met. All Health Boards have in place support services for staff and occupational health pathways, but broader preventative and restorative measures are required.

We recommend:

- The Welsh Government should develop and publish a **national service specification for perinatal mental health pathways** that encompass both common mental health conditions and moderate to severe conditions experienced by women, as well as services for fathers/ partners and parent-infant relationships.
- Health Boards should ensure that training is embedded for all staff in perinatal services on **recognising, responding to and preventing trauma**. This should also be completed by all involved in responding to incident processes, including legal teams. This will support the recognition, response and prevention of compounded trauma amongst women, parents and staff.
- Each Health Board should engage in a meaningful process with staff in perinatal services to seek an in-depth understanding of **staff mental health and well-being needs** and co-produce improved support and care structures. Health Boards should review and monitor the effectiveness of this through collaborative and transparent methods of engagement.

6: What is needed?

Optimal neonatal care commissioning

Babies who require neonatal services need to be cared for in the right setting; however, we heard consistent uncertainty over the current cot configuration across South Wales, poor co-ordination between units regarding cot and related maternity bed availability and stalled commissioning of out-of-hours neonatal transport services in the region.

Our panel also noted uneven provision of transitional care services across the whole of Wales, which increases the likelihood of babies being separated from their parents. In addition, both executive teams and clinical teams described delays in finalising staffing decisions due to the lengthy timescales associated with the NHS Wales Joint Commissioning Committee's neonatal transformation programme, despite the committee being composed of the of the seven Health Board Chief Executives.

We recommend:

- Commissioning: there is an urgent need for the NHS Wales Joint Commissioning Committee, to complete the required analysis and commissioning decisions relating to neonatal cot configuration and neonatal transport. This should also include consideration of how to maximise the quality and capacity of transitional care.
- In addition, the Welsh Government needs to accelerate plans to implement a national maternity bed and neonatal cot finder service. This should be based on a standardised model with 24/7 availability, dedicated staffing, robust senior clinical oversight, and a single, consistent telephone access point to ensure safe and timely system wide coordination.

7: What is needed?

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

As highlighted in Section 8, the response to serious adverse incidents such as a maternal death or serious injury or the serious injury or death of a baby, is inconsistent between Health Boards and too often is compounding the trauma experienced by families. The process is often a difficult experience for staff who feel blocked from apologising and debriefing with families by adversarial systems. Learning is also delayed by the prolonged processes. Health Boards often struggle to source external, independent reviewers leading to further delay. This is a long-standing issue that requires urgent and concerted action.

These challenges are shared across other UK nations, and there would be merit in the UK governments working together to develop clearer, more family-centred and restorative systems. Such an approach would offer several advantages, including the pooling of resources to commission standard operating procedures for perinatal incident responses that could be adapted and adopted across the UK. This is particularly relevant given that one of the key frameworks following stillbirth or neonatal death, MBBRACE-UK, already operates on a UK wide basis.

Greater alignment would also reduce variation for families who have received care in more than one UK nation, enabling them to experience a single, consistent process. In addition, it could support smoother and timelier cross-border arrangements for the identification and appointment of independent reviewers.

A consistent, timely and transparent approach to reviews of moderate to severe harm is required, incorporating external oversight and enabling greater involvement of families in the review process. Specifically, we recommend:

- A clear, accessible, publicly available **Standard Operating Procedure** for maternity and neonatal services in Wales for incident response and management. This should include a flowchart that demonstrates the processes and timescales that must be followed to align with Welsh legislation and guidance, and UK frameworks. It must be family-centred and trauma-informed, using restorative justice approaches.
- **A specialist subcommittee** of the National Strategic Oversight Board (as described in Priority 1) to oversee Health Boards' operational delivery of the perinatal National Reportable Incident process. This should include multidisciplinary clinical leads, a lay patient advocate, the Welsh Risk Pool and academic expertise to ensure that processes are family-centred, timely and learning is shared. It could also ensure that thematic learning is drawn from perinatal incident reporting and produce national thematic reports.
- **A national perinatal repository**, to include Local and National Reportable Incidents. which would enable and report on systematic and meaningful learning.

8: What is needed?

Developing an in-depth understanding of need, experience and outcomes through engagement and evaluation.

All Health Boards implement surveys and questionnaires as well as other methods to hear and engage with staff, woman, parents and communities to gain their views and experiences, but this rarely leads to meaningful involvement in service development. A Perinatal Engagement framework[36], published in February 2025 requires comprehensive methods for understanding experiences and involving women, parents and communities in service development. This will take commitment and resource by Health Boards to implement. Similar meaningful engagement and involvement methods should be co-produced with a range of staff groups.

In Wales, as in the rest of the UK, health inequalities are stark in perinatal services. We have observed a number of promising local initiatives led by Welsh Health Boards to address inequalities; however, their effectiveness requires evaluation and, where shown to be impactful, wider adoption and scaling.

The rapidly changing model of care in the UK needs further research to understand its costs and consequences. This report takes place during a period of reform in perinatal services, and these reforms, including those initiated by our recommendations, should be properly evaluated.

We recommend:

- Health Boards should improve how women's, families' and communities' experiences and views are heard and acted on by optimising the implementation of the Perinatal Engagement Framework.
- Health Boards should improve how the experiences and views of staff are heard and acted upon by implementing meaningful involvement approaches that are co-produced with staff groups.
- The Welsh Government, possibly jointly with the other UK Governments, should commission a programme of research on the costs and short, medium and long-term consequences of the current and emerging model of care
- Health Boards should test and evaluate initiatives to reduce inequalities of experience and outcome, particularly relating to poverty and ethnicity, and share findings at an all-Wales level
- The Welsh Government should commission an evaluation of the impact and outcomes of the priorities recommended here.

Summary Table of Recommendations

Priority

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

What needs to happen

A strengthened collective national oversight of perinatal services is needed, with the requisite authority and comprehensive understanding to drive continual improvement and nationally consistent standards of care and safety.

Recommendations

a. A National Perinatal Team

Responsibility: Welsh Government, NHS P&I

The appointment of national Clinical Directors or leads in obstetrics, neonatology, neonatal nursing and obstetric anaesthetics

These roles should form a National Perinatal Team, working alongside the Chief Midwifery Officer to advise the Welsh Government, drive policy development and implementation, and provide strengthened clinical oversight and accountability of Health Boards and other perinatal service providers.

For national level oversight we recommend:

b. A National Strategic Oversight Board

Responsibility: Welsh Government, NHS P&I

This Board should include all relevant national stakeholders with responsibility for perinatal services, the national perinatal team, and a service user representative, with the aim of providing comprehensive oversight and shared accountability.The Board should meet regularly to provide a single, coordinated mechanism for monitoring and acting on multiple intelligence sources. It should advise Welsh Government on policy and practice gaps, identify and address inequalities in outcomes, share and scale good practice, and oversee delivery of improvement programmes through a co produced National Framework for Improvement aligned to the Quality Statement for Maternity and Neonatal Services.

Clear terms of reference should be agreed and published to ensure transparency of remit and accountability.

The Board should be supported by two specialist subcommittees: one focused on frequent review and action on quality and critical safety signals, and a second overseeing Health Boards' delivery of the perinatal National Reportable Incident process and the dissemination of learning.

i. A National Women, Parents and Communities Maternity and Neonatal Group

We recommend that the planned National Maternity and Neonatal Voices Panel also includes representatives from community advocacy organisations representing populations at increased risk of poorer experiences and outcomes in perinatal services, and that it elects a representative to sit on the national strategic oversight Board.

ii. A Perinatal Stakeholder Group

The assurance assessment panel has benefited significantly from advice and challenge provided by a wider stakeholder group. We recommend this group is formally retained, meeting quarterly with clear terms of reference to inform the national strategic oversight Board, and that its membership is expanded to include educators, researchers and student representatives.

We recommend that the national perinatal team convenes an annual, in person collaborative event with the National Strategic Oversight Board, the National Women, Parents and Communities Maternity and Neonatal Group, and the Perinatal Stakeholder Group. This event should agree national improvement priorities, set shared approaches to delivering change, and review progress against actions from the previous year.

c. Data and monitoring

Responsibility: Welsh Government, NHS P&I, Health Boards

Urgent prioritisation of the national Beacon dashboard, with routine use embedded to support whole system learning and improvement, and regular public reporting.

A real-time safety signals dashboard, overseen by a clinically and academically informed subgroup of the national oversight group to enable early identification of risk and timely intervention.

d. National Governance

Responsibility: Welsh Government and NHS P&I

A comprehensive, accessible governance map, accompanied by a clear narrative explanation of roles, responsibilities, decision-making routes and escalation pathways, should be developed and published within six months of the publication of this report.

Priority

2 **A universal offer of quality care throughout the perinatal journey**

What needs to happen

Perinatal safety and quality must begin pre conceptionally and continue throughout antenatal care, intrapartum care, the postnatal period and into infancy.

Recommendations

Responsibility: Welsh Government, HEIW, Health Boards, HEI

We recommend that current rates of continuity of care by midwives are assessed in 2026–27, and that a meaningful, co produced plan is developed to increase continuity of care.

All maternity, neonatal and relevant education providers to actively progress through the stages of UNICEF UK Baby Friendly Initiative accreditation.

Health Boards should ensure that a birth discussion takes place with a suitable member of the multidisciplinary team involved in their care, before discharge from maternity services.

We recommend that Welsh Government supports Health Boards by providing clear, accessible and evidence-based public information resources, to enable consistent, accurate and timely communication with women, families and communities at a regional and local level.

Priority

3 **Urgent attention to critical clinical safety issues**

What needs to happen

The need for urgent attention to triage assessment and induction of labour. These are time and safety critical areas of care that can compromise quality and safety. Clear, consistently applied models for staffing and operational delivery are required to mitigate risk and ensure safe, timely care.

Recommendations

Triage

Responsibility: Welsh Government, NHS P&I

Welsh Government should progress at pace in 2026 with commissioning and implementation of the national triage line and publish a standardised national model for in person triage.

Induction of labour

Responsibility: NHS P&I

A national service specification should be developed to ensure consistent alignment with evidence-based guidance on informed decision-making, care planning and timely access to care. This should include a standardised service model setting out admission pathways, place of care, dedicated staffing, and routine consideration of induction capacity and flow within daily multidisciplinary perinatal huddles.

Priority

4 **Adequate staffing and estates to deliver safe and quality care**

What needs to happen

Staff across Wales are experiencing significant pressure due to workforce numbers and skill mix not reflecting the increasing complexity of care, high sickness levels and changing models of perinatal care, with particular gaps in allied health professionals, psychology and pharmacy.

Existing workforce tools support neonatal services but maternity workforce modelling, including for obstetrics and anaesthetics, does not yet reflect contemporary care needs; work to develop a comprehensive multidisciplinary workforce model has begun and must now be progressed at pace.

Recommendations

a. Concerted attention to current and future staffing needs

At a national level - Responsibility: HEIW

A multidisciplinary maternity workforce planning tool should be developed and implemented to align and integrate with BAPM standards for neonatal services. This tool should cover the full maternity pathway and include adequate provision for allied health professionals, psychology and pharmacy, as well as services for women with additional social and cultural needs.

At a health board level - Responsibility: Health Boards

- Must address immediate staffing pressures while national workforce specifications for maternity services are redeveloped.
- Must undertake a comprehensive review of obstetric workforce capacity taking account of service complexity, links with gynaecology, geography, and workforce sustainability.
- Should review midwifery and neonatal nursing staffing levels and skill mix to ensure compliance with Birthrate Plus® and BAPM standards, taking account of staff absence, and assess the sustainability and impact of time-limited specialist roles

b. A maternal medicine clinical network

Responsibility: NHSWJCC, NHS P&I

A review of clinical pathways for rare but serious pregnancy-related conditions, to ensure clear, consistent and commissioned routes to expert care within Wales or, where required, across the UK.

c. Adequate theatre estate and capacity

Responsibility: Welsh Government, Health Boards

Should review maternity theatre estate, capacity and staffing to ensure theatres are appropriately located, equipped and resourced for planned and emergency surgery.

Priority

5 Mental health support

What needs to happen

There are unmet mental health needs for women, parents and staff, with gaps in provision for mild to moderate needs, therapy and support for fathers, and limited availability of psychology services in clinical settings.

Staff support services exist, but broader preventative and restorative wellbeing measures are required.

Recommendations

Responsibility: Welsh Government, NHS P&I, Health Boards

Develop and publish a national service specification for perinatal mental health pathways covering common and moderate to severe mental health needs, services for fathers/partners, and parent–infant relationships.

Health Boards should embed trauma-informed training for all perinatal staff and those involved in incident processes and work collaboratively with staff to understand wellbeing needs and coproduce effective, monitored support arrangements.

Priority

6 Optimal neonatal care commissioning

What needs to happen

Babies requiring neonatal care are not consistently cared for in the right setting due to uncertainty over cot configuration, poor coordination of capacity, uneven provision of transitional care, delays in commissioning neonatal transport, and prolonged decision-making through national commissioning processes.

Recommendations

Responsibility: NHSWJCC, Health Boards

The NHS Wales Joint Commissioning Committee should urgently complete analysis and commissioning decisions on neonatal cot configuration, neonatal transport and transitional care capacity.

Responsibility: NHSWJCC, Health Boards

The Welsh Government should accelerate implementation of a national maternity bed and neonatal bed/cot locator with 24/7 availability, dedicated staffing, senior clinical oversight and a single point of access.

Priority

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

What needs to happen

The response to serious perinatal adverse incidents is inconsistent often compounding trauma for families, delaying learning, with adversarial systems that inhibit open apology, debrief and restoration.

Recommendations

Responsibility: NHS P&I

A clear, accessible and publicly available Standard Operating Procedure for maternity and neonatal incident response should be published for Wales underpinned by family-centred, trauma-informed and restorative approaches.

Responsibility: Welsh Government, NHS P&I, Health Boards

A specialist sub-committee of the National Strategic Oversight Board should oversee Health Boards' delivery of the perinatal National Reportable Incident process, ensure timely, multidisciplinary and family-centred responses, and produce national thematic learning.

Responsibility: NHS P&I

A national perinatal incident repository to enable systematic learning from local and national reportable incidents.

Priority

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

What needs to happen

Feedback is routinely collected from staff, women, parents and communities but rarely results in meaningful involvement in service development.

Recommendations

Responsibility: Health Boards
Improve how women's, families' and communities' experiences and views are heard and acted on by optimising the implementation of the Perinatal Engagement Framework.

Responsibility: Health Boards
Improve how the experiences and views of staff are heard and acted upon by implementing meaningful involvement approaches that are co-produced with staff groups.

Responsibility: UK Government, Welsh Government
A programme of research on the costs and short, medium and long-term consequences of the current and emerging model of care.

Responsibility: Health Boards
Test and evaluate initiatives to reduce inequalities of experience and outcome, particularly relating to poverty and ethnicity, and share findings.

Responsibility: Welsh Government
Commission an evaluation of the impact and outcomes of the priorities recommended here.

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