



Saving Babies' Lives 2026:

A report on progress

Wales briefing

October 2026

**Sands &
Tommy's**
Policy Unit

Working together
to save babies' lives

Summary of progress

- In recent years, there has been a lack of progress to reduce stillbirths in Wales. The stillbirth rate in 2024 (3.6 per 1,000 total births) was higher than it was in 2020 (3.48 per 1,000 total births), although it has declined by 4.8% since 2013 (3.78). When comparing the average over three years, there has been a decrease of 16.1% between 2013-15 and 2022-24.
- The neonatal mortality rate in Wales has been consistently declining since 2022, reaching a new low in 2024 (1.5 per 1,000 live births). Since 2013, the rate has decreased by 21.6% overall, but comparing the average of the past three years - 2022-24 to 2013-15 only shows an 8.5% decrease.
- Unlike stillbirths and neonatal deaths, the total number of miscarriages and miscarriage rates are not reported in Wales.

What needs to change

While there was an ambition in England to halve rates of stillbirth, neonatal death, preterm birth, maternal death and brain injury by 2025, relative to 2010, no equivalent for Wales has ever been set. The Welsh Government must set targets to reduce pregnancy loss and baby deaths and eliminate inequalities. Targets must have a clear baseline to monitor progress against and should be accompanied by a funded programme of policies to achieve them. This should include:

- The strengthening of national oversight for care, outcomes and service performance through the national Beacon maternity and neonatal Dashboard, drawing on data from Digital Maternity Cymru (the electronic patient records used across Health Boards). These data should inform improvements to maternity and neonatal services, identify the groups most at risk of pregnancy and baby loss in Wales, and provide more complete data on ethnicity and social risk factors.
- Regular collection and analysis of staff and patient experience, including insight from bereaved parents. The introduction of the National Perinatal Experience Measure in March 2025 should improve the availability of maternity experience data once results are publicly available.
- Consider how to align the field for recording miscarriage with coded values from the rest of the UK.
- Ensure that bereaved parents are supported to contribute to review of deaths, if they wish to, and that learning from reviews is systematically captured and shared across Wales.
- Consideration of mechanisms to ensure the timely completion of the Perinatal Mortality Review Tool for each perinatal death. In 2024, over a fifth (21%) of reviews started were not completed.
- Implementation of the All-Wales Maternity and Neonatal Assurance Assessment report recommendations, with progress monitored. The government should also consider lessons from investigations in England and Scotland and any implications for care in Wales.

Acronyms

BR+	BirthRate Plus
DHCW	Digital Health and Care Wales
FTE	Full-time equivalent
HIW	Health Inspectorate Wales
MOSS	Maternity Outcomes Signal System
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NNAP	National Neonatal Audit Programme
NQM	Newly Qualified Midwife
PMRT	The Perinatal Mortality Review Tool

Introduction

The Saving Babies' Lives 2026 report considers the systemic issues facing maternity and neonatal services across the UK. While each nation faces similar systemic issues, health is a devolved matter with policies and funding led by devolved governments in each of the four nations. Much of the data are also reported separately.

To analyse these data and support devolved policy makers, the Sands and Tommy's Joint Policy Unit is publishing a series of tailored briefings with the most recent insights for each of the four nations. This briefing is focused on Wales.

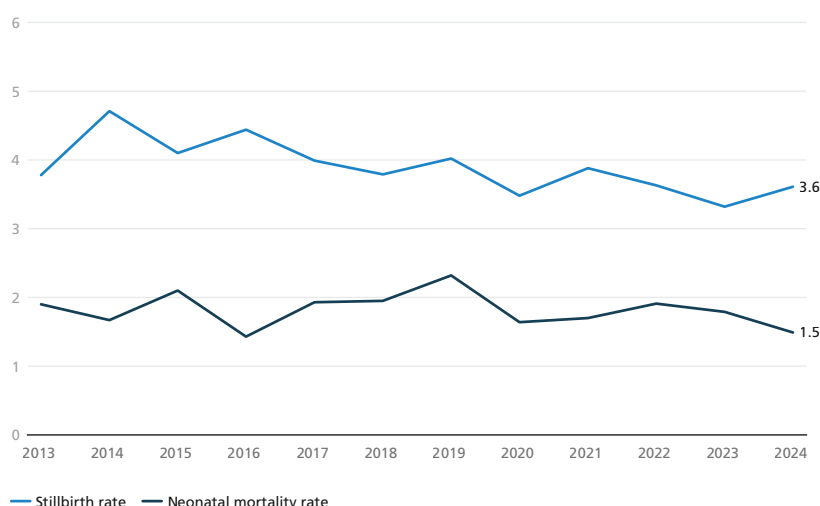
About the Sands and Tommy's Joint Policy Unit

Sands and Tommy's Joint Policy Unit is focused on achieving policy change that will save more babies' lives during pregnancy and the neonatal period and on tackling inequalities in loss, so that everyone can benefit from the best possible outcomes.

Rates of pregnancy loss and baby deaths in Wales

Overall, stillbirth and neonatal mortality rates have declined in Wales since 2013, although progress has been variable (see Figure 1).

While the neonatal mortality rate declined, the Wales' stillbirth rate increased in 2024



Stillbirth is the death of a baby after 24 weeks of pregnancy before or during birth per 1,000 total births. Neonatal mortality refers to deaths within the first 28 days of life for babies born at all gestational ages, per 1,000 live births. Source: MBRRACE (2026)

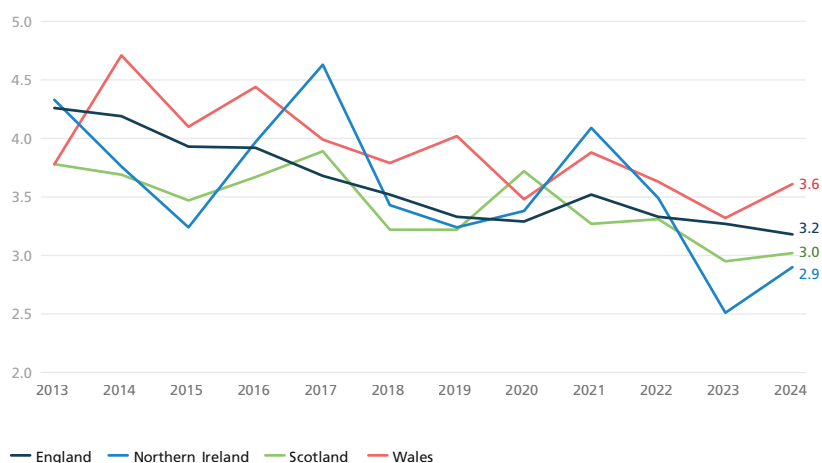
Figure 1. Stillbirth and neonatal mortality rate in Wales 2013-2024.

Unlike stillbirths and neonatal deaths, the total number of miscarriages and miscarriage rates are not reported in Wales, or by any UK nation. A new electronic patient record, [Digital Maternity Cymru](#), has replaced handheld records in Wales. DHCW has said that the record will include a field to record the reason for the closure of a maternity record. This presents an opportunity to record miscarriages which occur after women and birthing people have been booked onto maternity services. However, it is not clear whether this field is mandatory, is limited to coded values, or whether the coded values are aligned with those used elsewhere in the UK. Once data are recorded in this new system, the Welsh government plans to assess its quality and work towards regular reporting on this as part of maternity and births statistics in Wales. This would not capture miscarriages outside hospital settings and would be limited to losses which take place after women and birthing people are booked onto maternity services.

Comparisons across the UK

The stillbirth rate in Wales has been the highest of any UK nation for eight of the past 11 years. Smaller population sizes in Wales, Scotland, and Northern Ireland mean that slight changes can affect overall stillbirth and neonatal mortality rates, contributing to higher annual variability (see Figure 2). Comparing average stillbirth rates over three-year periods reduces the effect of this annual variability. Between 2013-15 and 2022-24 the stillbirth rate in Wales declined by 16.7%. The largest reduction was in Northern Ireland (-21%), while the rate declined 19.5% in England, and 13.9% in Scotland.

Stillbirth rates across the four nations 2013-2024

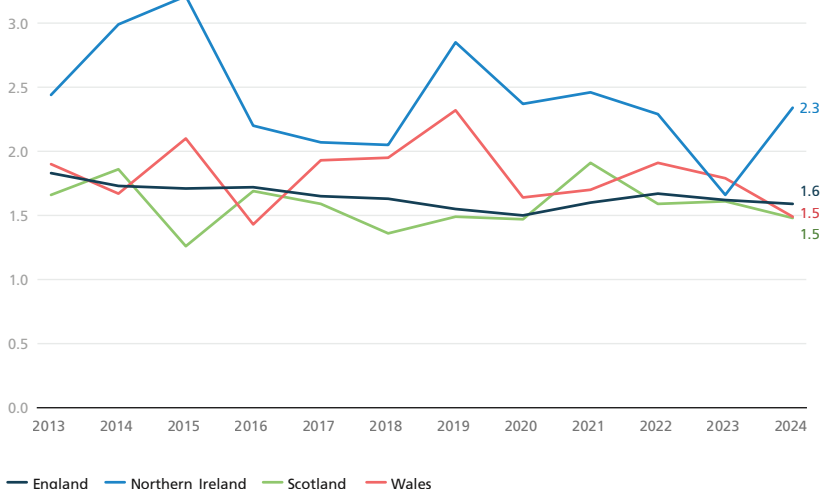


Stillbirth rate per 1,000 total births Source: MBRRACE (2026)

Figure 2. Stillbirth rate across the four nations between 2013 – 2024.

Between 2013-15 and 2022-24 the neonatal mortality rate in Wales declined by 8.5% (see Figure 3). The largest reduction was in Northern Ireland (-27.1%), while the rate declined 7.4% in England, and 1.9% in Scotland.

Neonatal mortality rates across the four nations 2013-2024



Neonatal mortality rate per 1,000 live births for babies born at 24 weeks' gestation and over. Source: MBRRACE (2026)

Figure 3. Neonatal mortality rates across the four nations between 2013-2024.

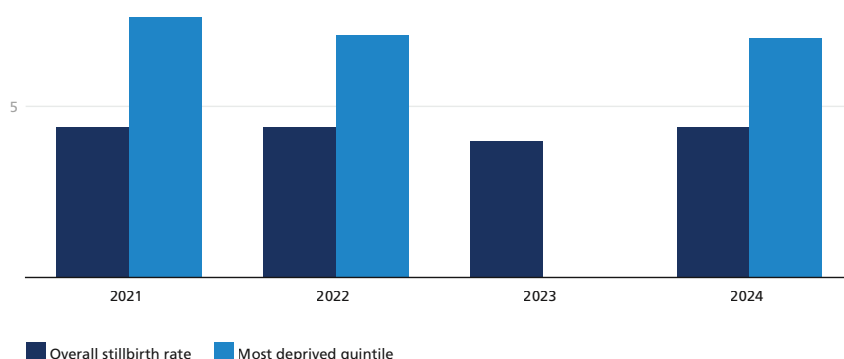
Inequalities in pregnancy losses and baby deaths

Across the UK, inequalities in perinatal mortality [continue to persist](#). In Wales, the [national assurance assessment of maternity and neonatal care and services](#) ('the Assessment') was published in February 2026 and revealed:

- A higher percentage of the population were classed as materially deprived (19%) compared to the rest of the UK (7%).
- Women and birthing people of childbearing age were over-represented in the most deprived communities.
- Births for women and birthing people in the most and second most deprived quintiles accounted for more than 40% of births in Wales in 2024.

In 2024, rates of stillbirth among those living in the most deprived areas of Wales was 45% higher than the overall stillbirth rate (see Figure 4). This difference has reduced since 2021, where stillbirths were 53% higher among those living in the most deprived areas.

In 2024, the stillbirth rate in among those living in the most deprived areas in Wales was 45% higher than the overall rate



The annual stillbirth rate for all Wales Index of Multiple Deprivation (WIMD) groups combined and for the most deprived quintile. Data classified as unreliable (including for all other quintiles of multiple deprivation) have been excluded. Source: StatsWales (2026)

Figure 4. Rates of stillbirth by deprivation in Wales, 2021-2024.

In Wales, better data are needed to identify the groups at most risk of pregnancy and baby loss as well as understanding what is driving inequalities and identifying potential solutions¹. The [Welsh Government](#) is improving data collection and analysis to better understand the experiences of Black, Asian and minority ethnic women and families and address inequalities in maternity and neonatal care. A key action for Health Boards is to work with the NHS Executive to implement the Perinatal Engagement Framework, engaging Black, Asian, minority ethnic, and other under-represented groups, to identify barriers to accessing services and improve outcomes.

One area where disparities in access to services are clear and may impact outcomes is when women and birthing people first engage with antenatal services. [In 2024](#), a higher proportion of women and birthing people living in the most deprived areas of Wales attended their first antenatal appointment, or booking appointment, after 10 weeks of gestation² (24.6%) compared to the least deprived (15.8%) and the proportion in Wales overall (23.7%). This was an increase overall in Wales from 2023 (21.3%) but remains lower than the average across Great Britain (24.4%). The percentage of late bookers was also highest among Black women and birthing people (45.3%) and lowest among White women and birthing people (16.9%). The booking appointment involves an important assessment of needs and risks to identify whether additional care and support is required so late booking may impact pregnancy outcomes.

1. In Wales, many data reported by ONS are marked unreliable due to small sample sizes and should be interpreted with caution.

2. The National Institute for Health and Care Excellence (NICE) [guidelines](#) recommend the first antenatal appointment takes place by week ten of the pregnancy, although initial contact and referral may have been earlier.

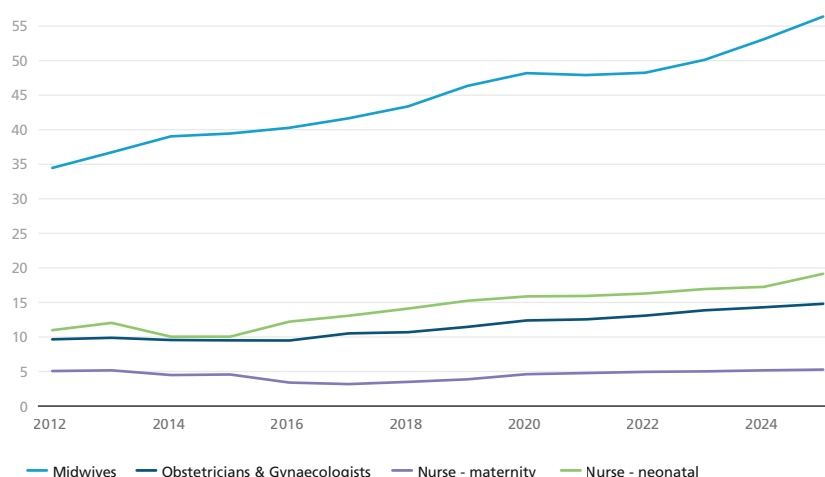
Systemic issues in maternity and neonatal services need to be addressed

The absence of regular, national reporting makes monitoring the quality of services across Wales challenging. Reports and assessments reviewed by the Sands and Tommy's Joint Policy Unit identified recurring issues affecting the safety of maternity and neonatal services. This section explores these issues in the context of Wales.

Workforce capacity and training

In Wales, the number of maternity and neonatal staff per 1,000 births has increased 58.8% since 2012 (see Figure 5). The number of midwives relative to births increased 64% between 2012 and 2025, partly driven by falling birth rates in the same period (-25.5%).

The number of FTE maternity and neonatal staff per 1,000 births has increased in Wales since 2012

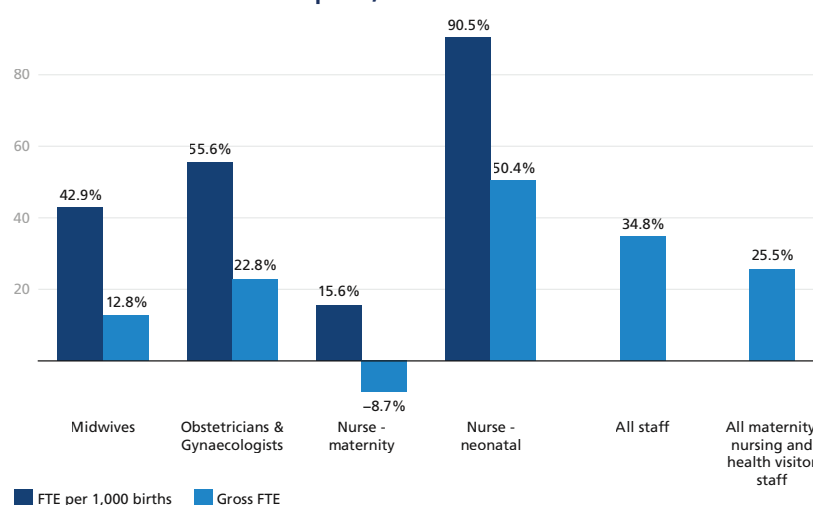


Full-time equivalent staff per 1,000 total births (live births and stillbirths). Annual averages have been calculated using the quarterly statistics published by StatsWales. Source: StatsWales (2026)

Figure 5. Average annual full-time equivalent (FTE) staff per 1,000 total births.

In the past decade, the nursing, midwifery and health visiting staff groups have grown by 25.5% which is lower than all staff groups in Wales (34.8%) (see Figure 6).

Total change in gross FTE staff working in maternity services over the past decade has been lower than calculations per 1,000 births

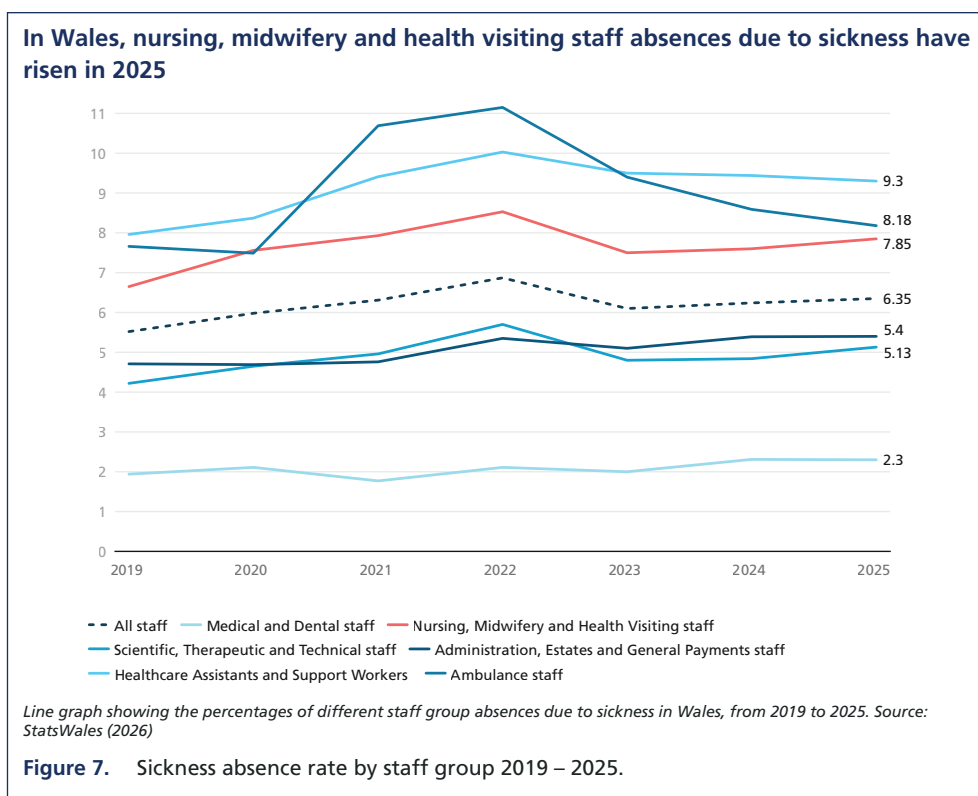


Full-time equivalent staff working in maternity services in NHS hospitals in Wales, showing total change between 2015 and 2025. View chart full screen. Source: StatsWales (2026)

Figure 6. Percentage change in FTE staff per 1,000 births and gross percentage change in FTE staff between 2015 and 2025 in Wales.

Despite the improvement in staff to birth ratios, staff report high levels of stress and burnout. [A survey](#) from one NHS Board in Wales found high levels of burnout. Levels of burnout for all NHS Wales staff increased from 28% in 2023 to 31.8% in 2024.

There are also high rates of staff absence due to sickness. Sickness rates among midwives, nurses and health visitors were the third highest of any staff group in Wales between 2019 and 2025, and 23.6% higher than the overall staff average (see Figure 7). The absence for all staff groups have risen slightly in 2025, suggesting pressure on services due to staff sickness absence remain broadly unchanged.



While birth rates are falling, the needs of the birthing population are changing in Wales, impacting the care required:

- The mean age of mothers and birthing people in Wales has slightly increased year on year, by 0.7% annually since 2023³. Pregnancy at advanced maternal age⁴, which has increased by [3.6% between 2022-25](#)⁵, increases the likelihood of [multiple pregnancies, co-morbidities and pregnancy complications](#), which require more monitoring during pregnancy and increase the demand on staff time.
- Obesity rates are increasing; almost a third (32%) of women and birthing people were classed as obese at their [initial assessment](#) in 2025, a 30.8% increase since 2016 (24.3%). Women and birthing people living with obesity are at higher risk of gestational diabetes, pre-eclampsia, caesarean delivery and neonatal complications.
- Mental health needs of pregnant women and birthing people are also [increasing](#) in Wales and were 8.7% higher in 2023 (32%) than 2017 (23.3%).
- Women and birthing people increasingly have long term physical (including obesity, diabetes), mental health conditions or social complexities which may require additional, and often specialist, staff time to provide the necessary support and referrals.

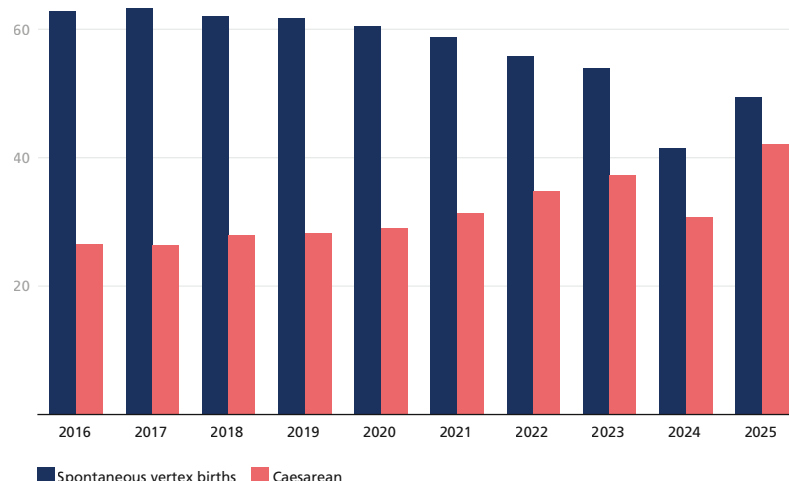
Mode of birth delivery is also changing, with an increase in caesarean sections and decline in spontaneous vertex births (see Figure 8). In 2025, caesarean sections now account for over [two in five births](#) (42%), the highest rate ever recorded in Wales.

3. Disaggregated data for Wales only are not available prior to 2023.

4. Defined as a woman or birthing person who will be aged 40 years or over at the time of giving birth. While some sources define advanced maternal age as 35 years or over, this document uses 40 years and over as the threshold throughout.

5. Disaggregated data for Wales only are not available prior to 2023.

In Wales, spontaneous vertex births remain the most common but are declining while caesarean sections are increasing



Modes of birth in Welsh hospitals, 2016 to 2025 for spontaneous vertex and caesarean births. See Maternity Indicators Dataset (MIDS) 'All births by mode of birth and local health board' for further information. Source: StatsWales (2026)

Figure 8. Comparison of spontaneous vertex births and caesarean birth percentages between 2014-15 and 2024-25.

Changes in the birthing population and clinical approaches affect all staff working in maternity and neonatal services. However, the workforce planning tool used nationally in Wales, BirthRate+ (BR+), is limited to midwives and does not adequately reflect the clinical and administrative demands on staff time. The Assessment recommends that Health Boards review their midwifery skill mix to ensure compliance with BR+ guidance, but this ignores the issues outlined in the [BR+ methodology review](#). Improvements to BR+ are required before enforcing compliance to ensure it accurately reflects the acuity of the modern-day workforce, while taking account of local staffing absence levels. An updated, multidisciplinary workforce planning tool is needed to accurately assess how many staff are needed in each role across the country.

The Assessment found that the skill mix of staff groups did not align with the complexity of population care needs, placing significant pressure on staff and contributing to high levels of sickness absence. Skill mix and staffing levels were the most common concerns highlighted by the Assessment.

Headline FTE data do not capture the skill mix or experience of staff working in maternity and neonatal services. The Assessment noted that the Welsh Government have implemented a guarantee for all newly qualified midwives (NQMs) a minimum 22.5-hour post. While this supported workforce entry, the Assessment notes that it also increased the proportion of entry-level midwives and neonatal nurses, diluting the skill mix and reducing the support available to NQMs. Staff reported that the higher proportion of Band 5 NQMs also limited opportunities to recruit more experienced Band 6 staff.

Understanding of workforce skill mix remains limited due to a lack of benchmarking data and insufficient information linking workforce composition to the care needs of women, birthing people, and their babies. The Assessment noted that Health Boards primarily relied on redeploying staff from other areas to maintain skill mix during busy periods. Improved data collection is needed to better understand workforce skill mix and ensure services are staffed with the right people in the right roles, with the right skills, at the right time to deliver safe care. The introduction of a multidisciplinary workforce planning tool would help to recognise the range of staff involved in care and factor in the time needed for training.

Leadership, governance and accountability

The Assessment found a positive shift in the attitudes and behaviours of Board members and national leaders over the previous two years. Feedback from pregnant women, birthing people, and their partners suggested that Health Boards were increasingly open about risks and willing to collaborate across organisations to improve perinatal care.

However, the Assessment also identified a fragmented national governance landscape. Oversight and improvement bodies were often found to be working in parallel, with unclear roles and responsibilities, and a limited understanding of how accountability for safety and quality was coordinated.

These challenges are also reflected within regulatory oversight arrangements. Healthcare Inspectorate Wales (HIW) inspects maternity services to ensure they meet relevant standards and guidance, with inspection reports identifying where services can improve. However, overall service ratings are not published. Greater accountability is needed to ensure that recommended improvements are implemented effectively and that progress is monitored through regular follow-up and reassessment.

Due to its smaller population and workforce, the Assessment noted challenges in embedding independent scrutiny, external perspectives, and benchmarking; some teams were not fully aware of gaps in their practice.

The shift towards Boards listening to and incorporating staff experiences is a positive development. [Digital Maternity Cymru](#) has replaced handheld records with a shared digital system, which offers the opportunity to improve how data are collected and monitored. However, it remains unclear whether these developments will provide the level of oversight and accountability needed to drive sustained improvement (see Data, monitoring and assurance section).

Data, monitoring and assurance

While maternity dashboards are used across all Welsh units, differences in data collection and reporting have previously limited the ability to compare performance and benchmark services between Boards. The Assessment notes that a national dashboard (Beacon) for maternity and neonatal services has now been implemented, which will draw on consistent electronic patient records across Health Boards. This is intended to strengthen national oversight and monitoring of care and outcomes.

The Assessment also recommended the adoption of a safety signals alert system, such as the MOSS⁶ dashboard in England, to enable real-time monitoring of key safety indicators across maternity and neonatal services in Wales.

Effective oversight of quality, safety and equity depends on timely, consistent and nationally comparable data. This enables variation in outcomes between population groups and clinical sites to be identified and acted upon. Whether the Beacon Dashboard can provide the comprehensive, timely and nationally comparable data needed to support safer services, drive improvement, and address inequalities in maternal and neonatal outcomes remains to be seen.

Engagement with service users

While there were examples of effective engagement with women, birthing people and families within Health Boards, these were often dependent on individual commitment rather than consistently embedded structures. Recent initiatives, including the Quality Statement for Maternity and Neonatal Services⁷ and the Perinatal Engagement Framework⁸, aim to strengthen and systematically embed service user involvement in service evaluation and improvement.

Women and birthing people's experience of care is also not regularly surveyed in Wales. The National Perinatal Experience Measure was introduced in March 2025, but it is not clear if work on this has started yet. Although this survey should offer insights into patient experience, surveys such as this need to be designed with bereaved parents in mind to ensure suitability.

Women and families emphasised the value of community and peer support services as an essential component of care, playing a key role in providing support and advice. Access to these groups was found to be variable, highlighting opportunities being needed to strengthen support.

6. See the main progress report for further information on MOSS.

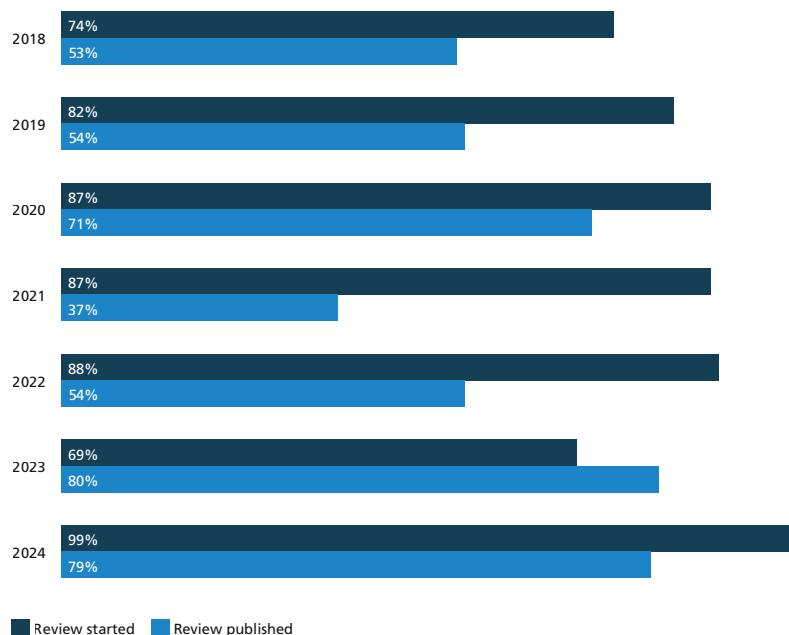
7. The Quality Statement for Maternity and Neonatal Services describe what services should look like and includes 12 health and care elements structured under six domains of quality.

8. The Perinatal Engagement Framework aims to engage women, birthing people and their families with Health Boards for co-production and informing care provision, prevention and reduction of inequalities.

Learning from reviews and investigations

When serious incidents or deaths do occur, reviews and investigations are essential to understand what went wrong, provide answers for families and prevent avoidable deaths in the future. The [Perinatal Mortality Review Tool](#) (PMRT) has been developed to standardise the review of perinatal deaths and create action plans for improvement. A timely review of care is important for parents and the NHS, to ensure understanding and reducing future avoidable harm. Since the Perinatal Mortality Review Tool (PMRT) was introduced in 2018, the proportion of perinatal deaths reviewed within the same year has generally increased in Wales and has been around 80% for the previous two years (see Figure 9).

In Wales, the proportions of perinatal deaths with a review of care started and completed are improving



PMRT reviews of perinatal deaths in Wales. Source: PMRT (2025)

Figure 9. Proportion of perinatal deaths with a PMRT review started and a review completed by year in Wales, 2018-2024.

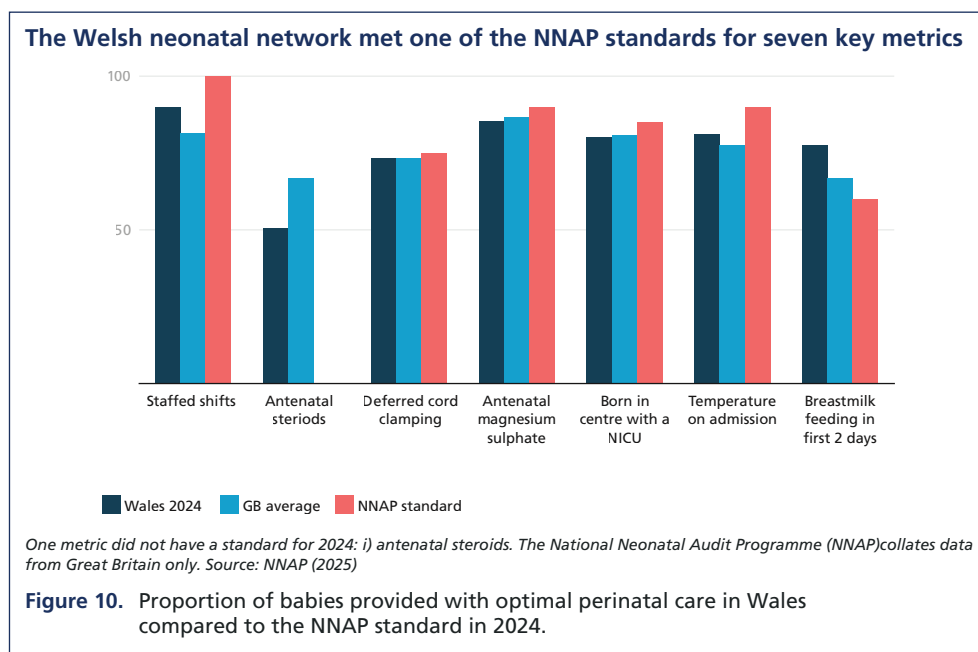
In 2024, a review was started for all stillbirths and late miscarriages occurring in Welsh Health Boards, with a 90% completion rate. For neonatal deaths, a review was started for 94% of deaths in 2024, but with a much lower completion rate (58%). The proportion of completed perinatal reviews is lower in Wales compared to England (89%), but higher than Scotland (43%) and Northern Ireland (36%). Incomplete reviews mean that any learning for health services and staff is not captured or acted upon, which could lead to repeat of avoidable harm in the future.

Involving parents is a critical component of reviews; ensuring that parents are given the opportunity to ask questions or share concerns. In 2024, 88% of Welsh reviews noted that parents' perspectives had been sought, but only 38% of reviews included parents' comments. Further work is required to support parents to engage if they wish to do so. The Assessment found that engagement with women and families during investigations was inconsistent across Health Boards, with opportunities for meaningful involvement not routinely embedded. Gaps were also identified with incident learning and oversight. One recommendation from the Assessment was to establish a specialist subcommittee to ensure learning is systematically captured and disseminated across Wales.

Delivering care in line with nationally agreed standards

Nearly all (93%) of the PMRT reviews completed in Wales during 2024 found at least [one issue with the care](#) that was provided. Across the UK, 1 in 5 reviews identified at least one issue with the care which may have prevented a late miscarriage, stillbirth or neonatal death. Too often, avoidable deaths occur because of care that is not in line with nationally agreed standards.

One example of variation in care is the care provided to preterm babies. The National Neonatal Audit Programme (NNAP) assesses the care provided to preterm babies in neonatal networks across Great Britain. Care is assessed across key measures which are aligned to professionally agreed guidelines and standards. Wales is currently below target for all bar one of seven metrics with standards (see Figure 10).



Reducing unwarranted variation is essential to save more babies' lives who are born preterm and are at higher risk of neonatal death. [Our briefing](#) looks in more detail at six of the NNAP optimal perinatal care measures; analysing level of adherence to understand why variation exists, and how to save more babies' lives.

The [National Patient Safety Plan for NHS Wales 2026-2031](#) aims to prevent harm and reduce unwarranted variation through the [Quality Outcomes Framework](#)⁹. Maternity services have been named as one of the priority areas.

9. The Quality Outcomes Framework provides measures for benchmarking against, with the aim of providing assurance against harm and safety indicators.

Sands & Tommy's Policy Unit

Working together
to save babies' lives