What needs to change to deliver safer maternity and neonatal services?

Sands & Tommy's Policy Unit

Working together to save babies' lives

Findings from our call for evidence – July 2025

Summary

- Reports and reviews into the safety of maternity and neonatal services across the UK consistently identify similar themes, which keep recurring despite steps to implement recommendations from past reports.
- Following work to collate these themes, the Sands & Tommy's Joint Policy Unit launched a call for evidence, inviting people working in maternity and neonatal services in the UK, and families who have experienced them, to share what they think needs to change.
- Through this process we have identified some key areas where a focus is needed to make progress, which include the need for:
  - **A comprehensive assessment of staffing requirements, which moves beyond just numbers, to the skills and mix of staff needed to deliver safe care.** Lack of staff resources and capacity was frequently raised as an issue. This included staffing levels (including overall numbers of staff but also having the right mix of staff roles with the right skills), a lack of training, knowledge gaps in particular areas, and staff not having appropriate guidance and support to help them implement changes in their services.
  - **A shared understanding of what is meant by 'safety'.** Responses to the call for evidence indicated that people have different understandings of what is meant by 'safety' and 'safety culture' in maternity and neonatal care. Some people interpreted this as improving outcomes, whilst others focused on ensuring pregnant women and birthing people have a positive experience. This lack of clarity is a barrier to progress.
  - **Addressing a perceived conflict between delivering care in line with national guidelines and personalisation/choice.** The relationship between standardisation and personalisation of care was raised multiple times. This included perceived issues with the implementation of national guidance that some respondents felt may be impacting on people's ability to make choices. This is despite relevant national guidelines making reference to informed choice. NICE states that their guidance helps women to make informed choices about their pregnancy and birth, and helps to reduce variation in care.

This report covers these areas in more detail, as well as others identified through the findings of our call for evidence. The findings highlight both the current barriers to delivering safer services and ideas for potential solutions.

Background

Reports and reviews into the safety of maternity and neonatal services across the UK consistently identify similar themes, which keep recurring despite steps to implement recommendations from past reports. The Sands and Tommy's Joint Policy Unit reviewed 30 reports into the safety of maternity and neonatal services across the UK. The reports reviewed are available in a briefing here. For each of these reports we identified recommendations relevant to saving babies' lives and tackling inequalities, and then grouped these into key themes.

These themes are:

1. Staffing and training
2. Personalisation of care
3. Safety culture
4. Organisational leadership
5. Data collection and use
6. Reducing inequities
7. Learning from reviews and investigations
8. Delivering care in line with nationally agreed standards
9. Engaging with service users

Following this analysis, the Sands & Tommy's Joint Policy Unit invited people working in maternity and neonatal services in the UK, and families who have experienced them, to share what they think needs to change to make progress on each of these themes. The call for evidence was intended to help identify actions needed to make progress on improving safety.

The following report contains the main findings from our call for evidence. The findings highlight both the current issues and ideas for potential solutions. For each theme we have highlighted 'areas to focus on to support progress', where further thought, discussion, or research is needed, to understand how we can resolve some of the tensions and challenges to reach consensus on how we can improve maternity and neonatal services.

Overview of findings

As highlighted in the summary above, some topics were raised repeatedly across the different themes, suggesting that these were issues that impacted many different aspects of maternity and neonatal care. Listed below are the topics that appeared within the themes, separated into issues and potential solutions.

1. Staffing and Training

Reviews have consistently found that maternity units are not staffed to safe levels, with staff saying they feel burnt out and under pressure. It is crucial that staffing levels are sufficient to ensure safe care.

Workforce plans must be owned by the board with clear mitigation and escalation policies in place when staffing is unsafe. However, it was clear from the responses to our call for evidence that this is not the case for many units.

The main issues highlighted through our call for evidence for this section were:

- Lack of staff
- Issues with training
- Staff attitudes and behaviours

Solutions that respondents proposed were:

- Increasing staff and better workforce planning
- Improving career progression and retention policies
- Increasing funding for services
- Improving training provision and content

Areas to focus on to support progress:

- How can services effectively calculate the number and type of staff actually needed in a unit on any given shift, so that units are well-resourced and staff feel able to provide safe care?
- What retention policies would increase retention of staff and skills in the workforce?
- How can staff attitudes and behaviour be improved, even where workforce capacity cannot be increased?
- How can training for staff be improved, which recognises existing training packages, avoids duplication and ensures that they are well equipped to care for patients?

2. Personalisation of care

All women and birthing people should be able to make informed decisions about their care. This includes decisions about mode and place of birth – based on full, impartial information about the safety risks associated with all birth options. The responses to our call for evidence raised significant concerns about whether this is happening consistently across services, and also highlighted areas where this can lead to tensions amongst staff but also between staff and patients.

The main issues highlighted were:

- Resources and capacity in the workforce
- 'Out of guidelines' care

Solutions that respondents proposed were:

- Improved documentation of women and birthing people's preferences and decisions
- Improving antenatal and postnatal education
- Continuity of carer

Areas to focus on to support progress:

- How can we encourage personalised care if staff do not feel they have the resources or capacity to provide this?
- How can staff be better supported to provide 'out of guidelines' care? How can we ensure that we are following national guidance whilst also supporting informed decision-making?
- How can we effectively minimise the risk of misinformation (eg from social media) and be more transparent about risks and benefits associated with different choices?
- How does continuity of carer affect patient safety?

3. Safety culture

It is important that services have a strong safety culture. Staff must be able to escalate concerns about clinical care whenever necessary, with clear protocols in place to support this. They should also be able to report concerns, without fear of reprisal or repercussions, however responses demonstrated that this does not always happen.

The main issues highlighted were:

- Bullying and blame culture in services
- Lack of openness and accountability when things go wrong

Solutions that respondents proposed were:

- Having an independent way of reporting concerns
- Improving systems that log incidents
- Improving training to support safety (e.g. training in management, human factors and psychological safety)
- Defining what is meant by safety

Areas to focus on to support progress:

- What would a truly independent process for reporting concerns look like, to ensure anonymity and that there is no risk of negative repercussions on those reporting?

- Does the reporting of incidents need to be reviewed? Are new approaches to this (including PSIRF) adequate to reflect concerns?
- What training do managers and senior staff have in dealing with and responding to safety concerns?
- Can we be clearer in what we mean by safety to ensure that everyone is working towards the same goals?

4. Organisational leadership

Safe care must be a shared goal throughout organisations, with boards taking effective ownership of the safety of maternity services with strong oversight of quality and performance of services. Responses showed clear issues with service leadership, including at board level.

The main issue highlighted in this section was that boards were not accountable and responsible. Responses showed that they were not always open and honest when things had gone wrong in their services.

Solutions that respondents proposed were:

- Collecting and sharing patient experiences with senior management (particularly at board level)
- Leadership being more transparent about performance and actions that will be taken
- Improving the capabilities of the leadership team

Areas to focus on to support progress:

- How can we ensure more meaningful patient experience is shared at board level?
- What data and information from boards should be publicly available? How can we ensure greater transparency and clarity over measures boards are taking to improve services?
- Does the make-up of boards and leadership structures need to be reviewed? Who/what roles should be part of the leadership team to ensure representation and expertise?

5. Data collection and use

Data collection must help identify variation in outcomes between maternity units, and among different patient groups. Steps must be taken to understand the causes of variation and to inform improvements. Better data collection needs to be supported by improving access to digital maternity records. Responses to our call for evidence made clear that issues with data and digital systems in maternity units persist.

The main issues highlighted were:

- Data fragmentation across the health service
- Lack of transparency and parents' access to data
- Data gaps

Solutions that respondents proposed were:

- More data sharing (between systems and different units)
- Improved capabilities of the workforce and training
- Understanding issues with the current data systems

Areas to focus on to support progress:

- How can data sharing and inter-operability of systems be improved, considering costs and limitations of the current systems?
- A digitally competent workforce is a key element of the NHS workforce plan, but what does this look like in practice? Do staff need more training or do services need more specialist data roles?
- What can we learn from other countries or systems to improve data collection and analysis? E.g. From programmes such as NIMACH (Northern Ireland Maternal and Child Health)
- Would an audit of data collection be helpful? Do we have a clear idea of the current issues and how can we identify where the data gaps are?

6. Reducing inequities

We know that women from minoritised ethnic backgrounds and areas of higher deprivation continue to experience poorer care and worse outcomes. Targeted care improvement initiatives for those at increased risk of worse outcomes are needed to reduce rates of miscarriage, stillbirth, neonatal death and preterm birth, and disparities in outcomes between groups. Better data collection of social risk factors is required to improve understanding of drivers of disparities and to inform care pathways. This includes accurately recording ethnicity data, and using it to respond to risk factors.

The main issue highlighted in this section was that patients from minoritised ethnic groups or other marginalised groups did not feel listened to and some felt that they experienced poorer care.

Solutions that respondents proposed were:

- Implementing different models of care (including case loading and pregnancy circles)
- Understanding and improving factors outside of maternity services, including those that require wider government action, but also actions that health services could take themselves to mitigate risk in pregnancy

- Improving access to interpreters
- Having better data, research and analysis to understand what is causing the disparities in outcomes amongst groups
- Having a well-trained, representative workforce

Areas to focus on to support progress:

- Delivering different models of care for at-risk groups that aren't yet evidence-based – what is preventing evaluation being embedded into the implementation of new initiatives so we can see their impact on outcomes?
- How can we collect more comprehensive data on a range of factors to understand disparities?
- How can we improve the provision of interpreters and deliver better care to those with language needs?
- How can services mitigate risks/issues associated with social deprivation?

7. Learning from reviews and investigations

There should be a standardised, consistent approach to reviews and investigations of serious incidents, with families involved in a compassionate manner. Systems must be in place to support the sharing of learning locally, regionally and nationally – with clear actions implemented to address concerns raised. The Perinatal Mortality Review Tool (PMRT) was developed to provide answers to bereaved families, explore whether different care would have made a difference to the outcome, and share wider learning to help implement care quality improvements. However, responses to our call for evidence showed that issues remain around the quality of reviews and that outcomes and learning are not always disseminated across services.

The main issues highlighted were:

- Families not being sufficiently involved in reviews and investigations, or not being involved in a compassionate way
- Timeliness to undertake a review of care and provide answers to families
- Lack of openness

Solutions that respondents proposed were:

- Clearer guidance on the current processes for staff
- Embedding a learning culture
- Disseminating learnings and outcomes to all staff

- Resourcing the workforce to be able to engage properly with investigations

Areas to focus on to support progress:

- How can high-quality reviews be implemented in practice? Is there a need for processes for investigations to be made clearer or do these processes need to be reviewed?
- How can we move towards a learning culture?
- How can we hold services accountable for implementing changes?
- Some responses reflected an imbalance between staff and family perspectives – how can we improve engagement with families?[1]
- Do we know what staff need to be able to engage fully with reviews and investigations? This could include more time, support, skills (including soft skills like facilitation as well as role specific skills)[2]
- How can we improve the timeliness of reviews? What are the causes of delays – staff capacity, a shortage of perinatal pathologists, or involvement with external organisations?

8. Delivering care in line with nationally agreed standards

Reports have consistently highlighted the need to provide timely and responsive care in line with national guidelines. This includes areas such as: risk assessment, fetal monitoring during labour, management of pregnancies with complications and management of preterm birth. Reports, such as the Ockenden report, have highlighted that adherence to national guidance varies across services, and responses to our call for evidence reflect this:

The main issues highlighted were:

- The amount of guidance and lack of resources for implementation
- The relationship between standardisation and personalisation of care and choice
- Local guidance that differs from national guidance

Solutions that respondents proposed were:

- More funding and resources to allow staff to deliver care according to national guidance
- More dissemination of information and making guidance more easily understandable and accessible
- Ensuring adherence to guidance and implementation (an authoritative body to take ownership of implementing recommendations and guidance)

1 The DISCERN study looked at how to improve open disclosure with families after things go wrong while receiving NHS maternity care.
2 The DISCERN study's recommendations include clear guidance on training needed for healthcare professionals, along with processes for setting up better systems to support parents and families during these ongoing discussions.

Areas to focus on to support progress:

- What would an authoritative body for overseeing monitoring and implementation of recommendations and guidance look like? Does one already exist?
- Can we develop a system to collate and prioritise recommendations/guidance (that is easily accessible to staff)?
- How can we ensure that Healthcare Professionals are following national guidance whilst also supporting informed decision-making? Does guidance need to be more flexible to ensure that informed choices can always be supported, or do staff need more resources to support women's choices?
- Is there a clear understanding of how local guidance interacts with national guidance? When is it justified for local guidance to vary from national guidance?

9. Engaging with service users

Services must actively engage with, learn from and listen to the needs of women and birthing people. This includes ensuring they are involved in reviews and investigations and consulted on the design and delivery of services. Responses to our call for evidence highlighted barriers to engagement and offered some solutions to help overcome them.

The main issues highlighted were:

- Engagement with service users not being meaningful or leading to changes
- Engaging families in investigations

Solutions that respondents proposed were:

- Ensuring that there are a range of ways in which service users can voice their opinions and feedback
- Proactive engagement to gain a diversity of views that represent the local population
- Better funding and resourcing for service users to enable them to share their views

In this section, some respondents also expressed that there needs to be more engagement from leadership with staff, particularly those that work clinically and on the front line, as well as with service users.

Areas to focus on to support progress:

- At which points in maternity care are there opportunities to obtain feedback from service users? Are there any opportunities for feedback that are not being used?
- How can the current methods of obtaining feedback be improved?
- How can feedback be better integrated into service design and delivery?
- How can services improve the diversity of views represented?
- Is funding for service user representation equal and available for all trusts?
- How can we ensure that engagement is meaningful? For example, ensuring follow-up with service users.
- How can parents be supported to engage with investigations? Data from the PMRT shows that the vast majority of parents are informed that a review will take place but many do not engage.

Any other comments

Finally, respondents were asked if they had any other comments that they had not yet had the opportunity to share. There were a range of responses relating to different topics and concerns:

- **Positive experiences of care:** A number of respondents used this opportunity to reflect on positive examples of good care that they had received.

- **Staffing:** Many responses stressed the importance of staffing levels and how a lack of investment in maternity and neonatal services is impacting care. As there was already a section on staffing, the fact that a number of respondents reiterated issues with staffing here suggests that it is one of, if not the most, significant factor in improving care for many people.

- **Standards and delivery of care**: Some responses reflected on standards and delivery of care. This includes ways of improving the maternity care journey, as well as issues with standards of care in some services.

There were a variety of other comments that appeared less frequently, which can be broadly grouped into the following themes:

- Responding to patient concerns
- Sharing information
- Continuity of care
- Personalisation of care
- Parent involvement and engagement
- Mental and physical health
- General concerns around maternity and wider healthcare
- Research

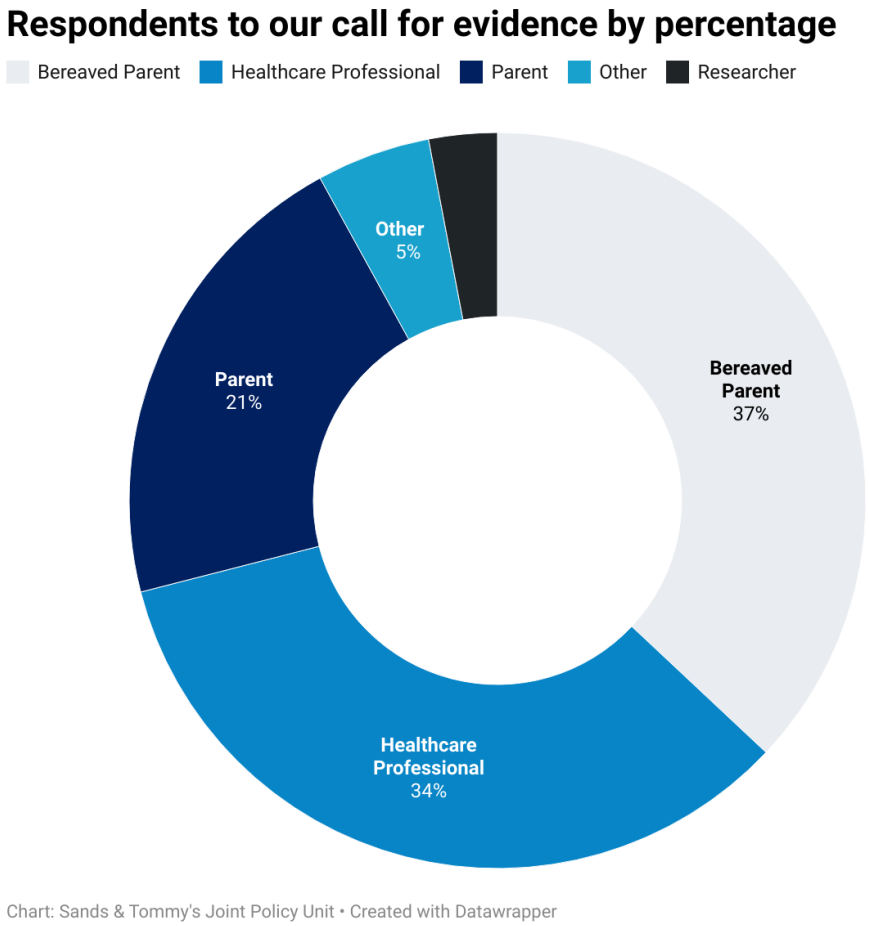
- The use of gendered language

Appendix 1. Methodology

We launched our call for evidence 22 April 2024 and it was open for responses until 1 July 2024. The online survey listed each of the nine themes with a small summary of the relevant recommendations that have been made and a free text box for people to write what they thought needed to change to make progress in that area. Respondents could choose to write comments for as many (or few) themes as they wanted. There was also a section at the end for any other comments.

The survey included optional questions relating to ethnicity, the person's professional background and the capacity in which the person was responding (e.g. personal or on behalf of an organisation).

We received 207 responses in total from a mix of healthcare professionals, bereaved parents, parents, service user representatives and organisations. These identities were self-reported.



Out of the 184 people that provided ethnicity data, the majority (71%) identified as White British. The next most frequently reported ethnicities were: Mixed White and Caribbean (2%), Indian (2%), Black African (1.5%) and Black Caribbean (1.5%). 8% of respondents identified as 'Other' which included other White European, American or Canadian, and other mixed ethnicities such as Mixed White and Arab.

Respondents also had the opportunity to explain their motivations for responding. These can be grouped into the following reasons:

- Having a personal experience of pregnancy or baby loss or knowing someone who has

- Having other personal experiences of maternity and neonatal care including trauma and poor care
- Wanting to bring about change and improve care for pregnant women and birthing people
- Working in maternity and neonatal services or related field, or having a specific interest in this area
- Feeling disempowered at work and wanting to improve the workplace environment for the maternity and neonatal workforce

Method of analysis

For each of the themes the Joint Policy Unit team read through the responses to identify similar ideas which we grouped into sub-themes. The responses for each theme were reviewed individually before discussing sub-themes in pairs. Once the sub-themes were agreed, the project lead coded all responses according to this framework. A list of the themes and sub-themes is available in Table 1.

Table 1. List of themes and sub-themes

Theme	Sub-theme
Staffing and training	Money/funding
	Training
	Need for more staff
	Workforce planning and management
	Staff behaviour and attitudes
Personalisation of care	Provision of information
	Understanding risks and benefits
	Shared decision-making and birth choices
	Maternity resources and staff behaviours
Safety culture	Raising concerns
	Hierarchy
	Accountability and openness
	Effective processes for improving safety

	Supportive working environment
Organisational leadership	Accountability and responsibility
	Consistent, clear insight and understanding of issues
	Management, competency, skills and support
	Willingness to change
Data collection and use	Data infrastructure
	Data gaps
	Data quality
	Transparency
	Analysis
	Capabilities and resources
Reducing inequities	Staff listening, awareness and attitudes
	Translation and interpretation
	Factors outside the health service
	Staff resources and delivery of care
	Community outreach and engagement
Learning from reviews and investigations	Review process
	Resources and training
	Learning culture
	Parent involvement
	Accountability
Delivering care in line with nationally agreed standards	Quality and feasibility of guidance
	Monitoring adherence to guidance

	Support and resources
	Variation in application of guidance
Engaging with service users	Diversity of views
	Family engagement in reviews
	Meaningful and proactive engagement
	Follow-up
	Resourcing
	Mistrust of services