Response – Independent Investigation into Maternity and Neonatal Services in England Interim report

Sands & Tommy's Policy Unit

Working together to save babies' lives

Key messages

The investigation must define what 'safe care' means and ensure recommendations come with clear responsibility, resources, and evaluation.

- Variation in care stems from unclear guidance, limited capacity to implement it, and weak oversight; streamlined national guidance and monitoring are needed.
- Cultural and leadership weaknesses across the system hinder safety, requiring better board capability, a genuine learning culture, and stronger national accountability.
- Tackling inequalities needs better data on social risk factors, culturally competent care, and properly funded interventions addressing racism and discrimination.
- Reviews of baby deaths should be simplified, family centred, transparent, and focused on learning that leads to action.
- Poor estates undermine safety, and investment is needed to ensure facilities are fit for purpose.
- Workforce planning must reflect the definition of safety, account for skill mix and population needs, and support multidisciplinary work.
- Monitoring and evaluation must be central, with clear outcome ambitions and improved data collection – including for miscarriage.

Introduction

The Independent Investigation into Maternity and Neonatal Services in England has published an interim report which included reflections from the Chair of the Investigation, Baroness Amos, on the issues facing services. While the issues highlighted in the report are not new, their systemic focus is welcome. The report examines six factors which could contribute to pressures on the maternity and neonatal system, namely: capacity pressures; culture and leadership; racism and discrimination; poor responses and lack of accountability when things go wrong; the quality of estates and workforce.

While understanding the problems is important, the investigation must also define what good looks like. Our research has found that there is not a shared understanding of what is meant by 'safety', with some focusing on improving outcomes and others focusing on ensuring pregnant women and birthing people have a positive experience. While these objectives are not necessarily in conflict, the investigation must build consensus on the definition of 'safe care', and the policy approach for achieving it.

The investigation will develop one set of national recommendations; it must consider the resources necessary to deliver them, name who will be responsible for delivering them, and commit to rigorous

evaluation of what works. The Taskforce should oversee progress against these recommendations and ensure delivery partners are held to account for timely implementation.

Tackling variation in service delivery must go beyond a focus on capacity pressures

The interim report describes variations in service delivery due to capacity pressures, particularly staffing levels, senior decision-making capacity, and physical infrastructure. Too often babies die because of care that is not in line with nationally agreed standards; the investigation must also consider other reasons for unwarranted variation in service delivery including, but not limited to, capacity issues.

Our research has highlighted several reasons for variation:

- ***Lack of clarity over guidance*:** the volume of guidance that exists means that it is a challenge for health care professionals to remain abreast of the latest developments. Where multiple pieces of guidance exist, including at national and local levels, there can be confusion over which to follow. There is also a perceived tension between delivering care in line with national guidance and personalisation.
- ***Lack of resources and capacity*:** staff lack the time to remain abreast of the latest guidance and resources to deliver care in line with them. Guidance should include implications for workforce requirements, setting out the skill and competencies required to deliver them.
- ***Lack of oversight of adherence to guidance*:** services are not held to account when care is not delivered in line with guidance.
- ***Lack of guidance*:** for some areas that are consistently highlighted as contributing to perinatal deaths (such as maternity triage or interpreting services), there is a lack of agreed national standards and guidance. While NHS England is currently developing guidance for maternity triage, the investigation should consider any other areas where guidance is insufficient.

Clear and simplified national guidance with sufficient flexibility to allow for local population needs is required, and dissemination improved. Staff need ringfenced time for training on guidance as well as the resources to deliver them. A national body should be created or nominated to monitor adherence to guidance.

Culture and leadership must be improved at every level

The interim report describes a maternity and neonatal system which faces many organisational and cultural issues, including poor working relationships and ineffective leadership, which impacts the quality and safety of services. NHS England has often pointed to their perinatal culture and leadership programme as a solution to existing issues with culture, leadership and teamworking. However, an external evaluation from the University of Birmingham found 'limited evidence' of change within services, and a failure to spread learning across the system, suggesting that the programme is not working as intended. It is vital that systems create a culture that encourages staff to share and escalate concerns, without fear of retribution.

The safety and quality of maternity and neonatal services are the responsibility of the board in each NHS Trust. However, our review of board oversight raised questions as to whether the information presented to boards and the review process were sufficient to give them a full understanding of the performance of maternity services in their Trust. There must be greater support for frontline staff to improve the quality and consistency of reports shared with the board (including guidance on minimum metrics that should be included and examples of good practice), as well as support for board members

to help them to contextualise and interpret the information that they receive. Boards must embed a culture of curiosity and learning rather than focusing on compliance and reputational management.

It is equally important to address issues with leadership and accountability at a national level. Despite numerous attempts by NHS England and the Department of Health and Social Care to respond to recommendations from past reports and reviews, safety and quality concerns continue to persist. It is all but certain that the government will not meet the National Maternity Safety Ambitions, which expired in 2025 (and will be reported in 2026), suggesting a lack of effective national oversight of the changes required. A stronger national leadership with clear accountability for the delivery and oversight of progress, including the prioritisation and sequencing of recommendations from multiples inquiries, is urgently needed to make progress.

Recognition of racism and discrimination is welcome, but action is needed

We welcome the explicit acknowledgement that racism and discrimination are impacting the quality of care and outcomes for women, birthing people, and babies, while acknowledging that some forms of discrimination remain under-recognised. We have outlined how routine data reporting (currently limited to ethnicity and deprivation) fails to adequately capture the breadth of women and birthing people's contexts, living circumstances, and identities which may affect pregnancy outcomes.

To address this, several actions are required:

- ***Agree and integrate additional metrics:*** key metrics related to social risk factors that can feasibly be recorded must be urgently agreed upon and integrated into NHS systems.
- ***Support staff to collect data sensitively:*** NHS staff must be trained to understand the importance of collecting these data and methods to do so sensitively and consistently.

Improving the quality and collection of data can help to inform a comprehensive, cross government approach to tackling inequalities in pregnancy and baby loss. In the immediate term, the government and the healthcare service must:

- **Adequately fund and pilot interventions** to tackle racism and discrimination and evaluate their impact.
- **Support staff to deliver culturally competent, personalised care** that recognises how racism and/or other social risk factors influence access, experiences, and outcomes.

In the longer term, solutions must extend beyond healthcare, addressing the wider drivers of inequalities that contribute to disparities in pregnancy and baby loss.

Reviews of deaths must be reformed to centre bereaved families and embed learning

Bereaved parents want answers about why their baby died and, where relevant, for lessons to be learned to prevent other babies from dying in similar future circumstances. To achieve this, the current system for reviewing baby deaths needs to be fundamentally restructured to centre bereaved families' needs and embed learning, through:

- ***Simplifying and improving the review process:*** to better enable parents to engage, should they want to. The current review systems are overly complex with unclear thresholds, with some deaths going through multiple reviews (e.g. PMRT, MNSI) which are disjointed and lack communication of findings.
- ***Removing the reliance on clinical notes:*** which currently limit opportunities for parents to feed in their perspectives or challenge findings. While healthcare professionals have a legal and professional obligation to be open and transparent with bereaved parents, with the Duty of

Candour, reality instead depicts cases of missing or inaccurate notes and reviews. This currently shows sub-optimal care to an opaque and defensive system, rather than one which needs to focus on learning and improvement.

- One suggestion is the creation of a single portal where parents can view all the information and reports in relation to their case and upload their evidence. Examples of this in practice show Denmark:

- **Danish Patient Compensation** gathers and centralises all documents and information relevant to a case in one place and assigns an individual case worker. This single point of contact supports families to understand the review process(es), share their perspectives and challenge findings, if required. Application of this system and a single case worker in England could drive a more empathetic and human-centred approach and support parents with their right to challenge inaccurate information.

After reviews have taken place, learning must lead to improvements in service delivery. This must occur through:

- ***Reviews focussing on systemic issues and ensure that recommendations are informed:*** by parental engagement, genuine and open reflection on what went wrong from staff and independent scrutiny.
- ***Staff time being ring-fenced***: to reflect on deaths in their maternity and neonatal services, implement recommendations and provide external oversight for other Trusts.
- ***Trust boards taking a more active role:*** in monitoring the implementation of recommendations and understanding their impact.
- ***National, regional, Trust, and frontline services' leadership all playing a role:*** in a cohesive and joined up system to ensure accountability for implementation.
- ***Local Maternity and Neonatal Systems and national bodies identify frequently occurring recommendations:*** and whether these are regionally and nationally respectively, what the level of implementation should be or barriers to doing so, and the overall impact.

Current reviews suggest actions, but there is little oversight of their implementation. There must be a system for updating bereaved parents with the actions that have been taken.

Improving the quality of estates will support the delivery of safer care

We welcome the interim report's recognition of the poor quality of the estates in which maternity and neonatal services are delivered. The CQC's national review into maternity services in England found that too many maternity units are not currently fit for purpose, lacking space, facilities and, in some instances, the appropriate levels of potentially life-saving equipment. Improving the quality of estates is therefore a critical component of delivering safer, more consistent outcomes for women, birthing people, and babies.

A nuanced discussion of workforce is required to deliver safe care

There is debate on the extent to which workforce shortages are responsible for the systemic issues within maternity and neonatal care. We welcome the interim report's recognition of a broad range of issues related to workforce and the impact they have on both staff and patient experience.

As we explain in the introduction, the first step to providing a safe service is to define a shared understanding of what is meant by 'safety', and then the staffing levels and skills mix required to deliver it. This should include a proper assessment of maternity and neonatal services' capacity and demand,

including the changing health profile of the birthing population, declining rates of spontaneous birth, time for training and supervision, and the creation of specialist or managerial roles. Workforce modelling must move beyond large staff groups (such as midwives) to consider the workforce requirements across all groups and how to support multidisciplinary teamwork.

Monitoring and evaluation must be central to the final report

A commitment to monitoring and evaluation must be central to the final recommendations. Initiatives that have been introduced in response to concerns about the safety of services in the past have often lacked a strong evidence base or have weak or non-existent evaluation, which limits learning and accountability.

As well as evaluating the impact of individual recommendations, the impact of the investigation and its recommendations overall should be measured by improvements to birth outcomes. We have previously called for the government to set new ambitions for reducing perinatal mortality and preterm births, focused on matching the best-performing countries in Europe, and we would emphasise the importance of Baroness Amos incorporating new ambitions within her recommendations.

There are no routine data available to monitor the rate of miscarriage nor suggest an ambition. First, a mechanism to count miscarriages across the health service must be developed along with a commitment to report data at a national level. Once routine data collection and reporting are in place, and there are sufficient data to analyse recent trends, an appropriate ambition should be introduced.

The interim report's diagnosis of the issues facing maternity and neonatal services provides hope that the investigation will focus on systemic solutions. It is critical that the investigation leads to meaningful action, which ultimately makes maternity and neonatal services safer and improve outcomes, for all.