



Saving Babies' Lives 2026: Summary briefing

October 2026

**Sands &
Tommy's**
Policy Unit

Working together
to save babies' lives

Introduction

Baroness Amos's Investigation into maternity and neonatal services in England concluded that urgent reform is needed to improve outcomes for babies and families.

This year's Saving Babies' Lives Report sets out five principles for a future system: safe, equitable, family-centred, accountable and evidence-driven. For each principle, we have posed questions that have not been adequately considered as part of the analysis to date. The questions included in the report will form the basis of the Joint Policy Unit's upcoming work, as we seek to address them.

Five principles should underpin systemic reforms to maternity and neonatal services:



1. Safe

How does the Taskforce define safety and how will it be measured?

The Investigation called for urgent reform to put safety at the centre of maternity and neonatal services. However, our research has found that there is not a shared understanding of what 'safety' means. The Taskforce must agree a shared definition of safety and how it will be measured. We have previously called for the government to set new maternity safety ambitions to reduce baby deaths and preterm birth and eliminate inequalities by 2035.

How will the national maternity standards be developed to ensure they incorporate the best available evidence?

The commitment to binding national maternity standards is welcome. Their development should review existing guidance, assess the strength of the evidence base, and agree how evidence and equity will shape the standards.

How can the national maternity standards allow sufficient flexibility for local population needs and patient preferences?

Some local variation may be appropriate, but it should be intentional, evidence-based and evaluated. The standards must balance national consistency with local needs and personalised care.

What funding and resources are required to deliver the standards, and will this be provided?

The standards must be feasible, cost-effective and fully funded, with the required resources identified from the outset.

How can multidisciplinary workforce planning tools be developed which accurately models the staff needed across services? Has this been done well in other services?

There is no agreed definition of safe staffing or consensus on how many staff maternity and neonatal services need. Current workforce tools are not sufficiently evidence-based or multidisciplinary. A new tool should reflect population need, clinical care, administration, education and training demands across maternity, neonatal and early pregnancy services.

Mandatory training requirements should be agreed and built into workforce planning, with additional time for local priorities.

How could education be reformed for professions working in maternity and neonatal services to embed multidisciplinary approaches?

Multidisciplinary teamwork is essential to safe care. Education reform could help embed shared objectives and collaborative working from the start of staff careers.

2. Equitable

What would 'success' in tackling inequalities look like in 10 years' time?

The Taskforce should set targets to eliminate inequalities in stillbirths, neonatal deaths and preterm births by ethnicity and deprivation. A 2035 target would align with the government's 10 Year Health Plan.

What are the critical data and evidence gaps in the current understanding of inequalities in maternity and neonatal and how can they be met?

Better data are essential to understand and reduce inequalities. The Maternity and Neonatal Equalities dashboard is useful, but limited by gaps in data quality and completeness.

Key metrics on social risk factors and protected characteristics should be agreed and built into NHS systems. Staff training and digital changes will be needed so data is collected sensitively and used to identify barriers and design solutions.

How does the Taskforce define deprivation and how will the Taskforce ensure inequalities by deprivation are given due consideration?

The focus on racism is welcome and urgent, but wider forms of discrimination and other drivers of inequality also need analysis.

Inequalities linked to deprivation have received less political focus, despite strong evidence. Because deprivation and ethnicity intersect, addressing deprivation is also important for tackling racial inequalities. The Taskforce should define deprivation consistently and ensure it is properly considered.

3. Family-centred

What would a maternity and neonatal system designed for, and by, parents rather than health services look like?

Maternity care is often fragmented, with women and birthing people seeing multiple professionals across pregnancy, birth and neonatal care. Services are shaped by acute care capacity rather than by parents' experiences and needs. The Modern Service Framework is an opportunity to redesign services with women, birthing people and families at the centre.

What data on personalised care and informed choice should be collected and how?

Since the publication of the Investigation, there has been debate about the conclusion that the Investigation "did not find that 'normal birth ideology' was currently widespread". There is limited national data on decisions about mode of birth or whether women and birthing people feel pressured to have a particular mode of birth. Patient experience surveys and additional mandatory fields in patient records could capture data on access to unbiased information, choice, and reasons for interventions.

How can staff be supported to give women and birthing people unbiased information and deliver compassionate and respectful care in line with their choices?

Safe, high-quality care must include listening to and respecting birth choices. Education, workplace culture and professional beliefs should be reviewed so staff can offer unbiased support.

Our research highlighted the challenge for staff when women and birthing people make choices outside of guidance. Staff need support to deliver care based on women and birthing people's preferences, including choices outside guidance. In some cases, personalised care may require additional resources.

How can culture within maternity and neonatal services be improved to ensure that parents' preferences and concerns are listened to?

Successive reports have stressed that healthcare professionals must listen to parents' concerns in real time to ensure escalation and action when required. Martha's Rule offers a process but does not address underlying cultural issues. As local adoption in acute services has depended on ward culture and staff attitudes, its impact - and evidence that it does no harm - should be established in maternity and neonatal services before wider rollout.

What would a comprehensive process for reviewing baby deaths designed for, and by, bereaved parents look like?

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 circumstances. The current system for reviewing baby deaths needs to be fundamentally restructured to centre bereaved families' needs, simplify processes, reduce the reliance on clinical notes, and embed learning.

4. Accountable

How can the Department of Health and Social Care (DHSC) / NHS England create a just culture to ensure individual and institutional accountability, promote learning and reduce adversarialism?

A just culture enables staff to admit and apologise for genuine mistakes and organisations to learn how to prevent recurrence. The current system instead fosters fear and blame: staff fear speaking out, unsafe care harms women, birthing people and babies, and families do not get answers. Individual accountability and system learning must go together, recognising systemic causes of error while addressing behaviour that falls short of legal and professional duties.

Is another governance structure required to enable true oversight and scrutiny of maternity and neonatal services?

Provider Trust Boards are responsible for maternity and neonatal service safety and quality. Recent Investigations, the Maternity Incentive Scheme and media attention have increased visibility of maternity and neonatal services, but it is unclear whether this has led to meaningful scrutiny or action.

Board members should be curious and open, but wider system pressures shape behaviour. Trusts and services must prioritise amid competing recommendations and requirements, while working within constrained budgets set by the Treasury and distributed through Integrated Care Boards. External responsibilities, such as targets, without the resources to meet them can drive reactive and defensive rather than constructive behaviour.

National accountability functions have evolved over time, creating a confusing and sometimes contradictory system rather than one designed holistically. Some functions may work well, but many organisations have accumulated roles that create tension, and national oversight bodies, including NHS England and DHSC, have faced insufficient scrutiny. The abolition of NHS England and creation of the Maternity Commissioner provide an opportunity to review governance, accountability and oversight, and design a coherent whole-system approach.

5. Evidence-driven

What are the critical data gaps in maternity and neonatal services and how can they be met?

The report highlights key data gaps, including miscarriage, inequalities and patient choice, and suggests ways to address them. Better data and evidence are essential for understanding service challenges and assessing improvement efforts.

How effectively are current tools and processes used (locally, regionally and nationally) to review data and evidence regarding the safety of services?

Existing data and evidence are fragmented and do not always provide actionable insights. New tools can help standardise metrics and reporting, but their effectiveness depends on data quality and how they are used. Robust evaluation is needed to understand their impact on maternity and neonatal safety.

How will the Taskforce ensure that evidence and evaluation are embedded in the action plan?

Many initiatives introduced to improve service safety lack robust evidence or evaluation. A renewed evidence-based approach to maternity and neonatal safety must ensure interventions are rigorously evaluated, with evaluation built into their design from the outset.

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