

Saving Babies' Lives 2026:
A report on progress

Sands & Tommy's Policy Unit

Working together to save babies' lives

October 2026

Foreword

When Sands and Tommy's came together in 2022 to form the Joint Policy Unit, one of our key objectives was to make saving babies' lives a political priority across the UK. On taking office, the new Secretary of State for Health and Social Care, Yvette Cooper, has made maternity care one of her key priorities and promised reform in England. Now, our attention must shift from making the case for prioritisation to using that focus for real and meaningful improvements.

Two major reports were published earlier this year in England: Baroness Amos's Investigation into maternity and neonatal services across England and Donna Ockenden's review of maternity services at Nottingham University Trust. These reports again highlighted how services are failing families and babies across England and underscored the need for system-wide reform, which the National Maternity and Neonatal Taskforce has been established to deliver through a comprehensive action plan.

In this year's report, the Joint Policy Unit sets out five principles that a reformed system must adhere to: safe, equitable, family-centred, accountable and evidence-driven.

For each principle, this report includes questions that have not been adequately considered as part of the analysis to date. These questions will form the basis of the Joint Policy Unit's upcoming work. As part of our roles in the Taskforce and the charity and third sector expert reference group, we will pose these questions and share insights from Sands, Tommy's, and the Joint Policy Unit to help the action plan achieve what is urgently needed to improve outcomes.

The Taskforce will be limited to developing an action plan for England, so the focus of this year's report, and the data it contains, is on England. However, the recent review in Wales and the upcoming investigation in Scotland show that these issues are not limited to England, and many of the questions posed would benefit from the devolved governments' consideration also.

This summer, the new Prime Minister, Andy Burnham, pledged to bring back hope. We hope that this year marks a turning point for maternity and neonatal services across the UK, when we move from investigation to action. We hope that this will be a moment to step back and think about what care should look like during pregnancy, birth and postnatally. We also hope that this will lead to the deep and lasting improvements that are so desperately needed.



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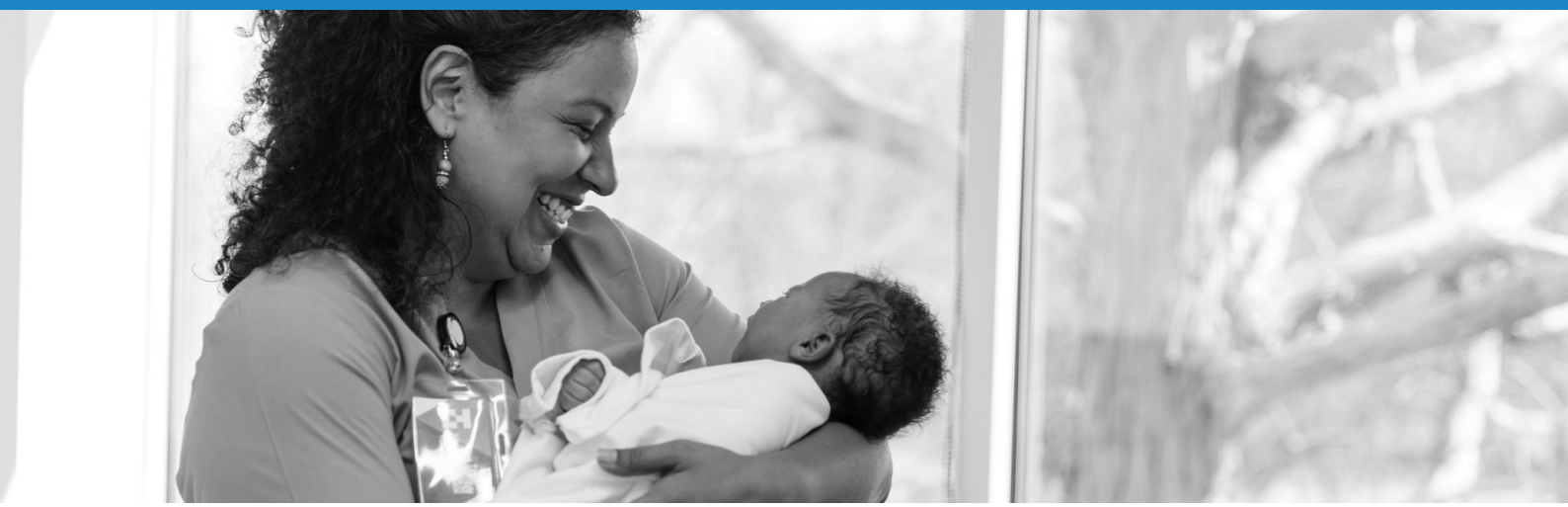
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Glossary

- **Advanced Maternal Age** – defined as a woman or birthing person who will be aged 40 years or over at the time of giving birth, in England. While some sources define Advanced Maternal Age as 35 years or over, this document uses 40 years and over as the threshold throughout.
- **Ethnicity** – a form of collective social identity which encompasses elements of physical features (such as skin colour and hair texture), language, culture, shared history and common ancestry. It is socially constructed and dynamic; identities and meanings are shaped by ethnic groups' own members and wider society. Ethnicity data are based on self-declaration by adults and on guidance from a parent, guardian or carer for children under the age of 12. This report refers to ethnicity, not race, in line with the official terminology used during data collection and reporting; however, the language used by individuals to describe their experience is personal and may vary. We do not use collective terms such as Black, Asian and minority ethnic (BAME) which emphasise certain groups and exclude others, while also masking differences between groups. Where it is necessary to refer to broad categories to describe inequalities, we refer to "minoritised ethnic groups" to recognise that individuals have been minoritised through social processes of power rather than existing in distinct statistical minorities.
- **Deprivation** – the term commonly used by governments and the NHS to describe a lack of income and other resources, which can also be referred to as socio-economic status. People may be considered to be living in poverty if they lack financial resources to meet their needs. Deprivation is a wider measure which goes beyond income to consider employment, health, education and skills, crime, housing and living environment. Deprivation is measured on a relative rather than absolute scale. Where we refer to people living in areas of high or low deprivation or within certain deprivation quintiles or deciles as deprivation, this is based on geographical area and not individual circumstances.
- **Deliveries** - the total number of distinct pregnant women and birthing people, with one or more babies born in the period. Although there are some critiques of this language, which centres the health care professional, rather than women and birthing people, this report reflects the language used in the underlying datasets to avoid introducing inaccuracies.
- **Neonatal mortality / neonatal death** – the death of a live born baby in the first 28 days of life. Usually expressed as the neonatal mortality rate per 1,000 live births. Early neonatal mortality refers to death before 7 days and late neonatal mortality refers to deaths between 7 and 28 days old. While neonatal mortality includes the death of a live born baby at any gestational age, some data are only reported for deaths at 24 weeks' gestation and above. Due to variation across sources, please refer to the notes of each figure to confirm the scope of reporting.
- **Perinatal** – describes the period surrounding birth, usually from about 24 weeks of pregnancy up to 28 days of life.
- **Preterm birth** – any live birth before 37 weeks of pregnancy. Preterm births can be further broken down according to gestational age: extremely preterm (less than 28 weeks), very preterm (28 to 32 weeks), and moderate to late preterm (32 to 37 weeks). The maternity safety ambition for England defines a preterm birth as any live birth or stillbirth with at least 24 but less than 37 weeks completed gestation.
- **Rate** – an amount of something measured per unit of something else. Where its occurrence is relatively rare the rate may be expressed per 1,000 or even 100,000 of the denominator. For example, the stillbirth rate is the number of stillbirths divided by the total number of births (live births + stillbirths) during a given period (usually per year). In 2020, the stillbirth rate in the UK was 3.3 per 1,000 total births, meaning that out of 1,000 births, 3.3 sadly resulted in a stillbirth.
- **Spontaneous vertex births** – vaginal delivery where the baby is in a head-first position and occurs without the use of instruments such as forceps.
- **Stillbirth** – the death of a baby after 24 weeks of pregnancy before or during birth. Usually expressed as the stillbirth rate per 1,000 total births (live births + stillbirths). Antepartum stillbirths are those which occur prior to labour, while intrapartum stillbirth is when a baby was thought to be alive at the start of labour but was born with no sign of life.
- **Women and birthing people** – the Sands & Tommy's Joint Policy Unit is committed to inclusivity and ensuring that everyone feels heard and seen. To recognise transgender and non-binary gestational parents, we refer to women and birthing people throughout this report. However, when referencing research, we will mirror the language used in the underlying study to avoid introducing inaccuracies.

Acronyms

CCG	Clinical Commissioning Groups
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
EPU	Early Pregnancy Units
FTE	Full Time Equivalent
ICB	Integrated Care Board
JPU	Sands and Tommy's Joint Policy Unit
MIS	Maternity Incentive Scheme
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MNSI	Maternity and Newborn Safety Investigations
MNVP	Maternity and Neonatal Voices Partnerships
MOSS	Maternity Outcomes Signal System
NHS	National Health Service
NICU	Neonatal Intensive Care Unit
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
ONS	Office for National Statistics
PMRT	Perinatal Mortality Review Tool
PREM	Patient-Reported Experience Measures
RCOG	Royal College of Obstetricians and Gynaecologists
SPR	Single Patient Record



1. Introduction: principles for a better system

Baroness Amos's Investigation into maternity and neonatal services in England (hereafter referred to as 'the Investigation') concluded that the maternity and neonatal system needs urgent reform to improve outcomes for babies and their families. Alongside the report, the National Maternity and Neonatal Taskforce has been established to develop a comprehensive action plan and hold the maternity and neonatal system to account for its implementation.

We welcome the conclusion that systemic and cultural change is required. In this year's Saving Babies' Lives Report, we set out what we believe a future system should be: safe, equitable, family-centred, accountable and evidence-driven. In each chapter, we briefly outline how the current system is failing to meet these principles and conclude with questions for the Taskforce to consider when developing the action plan, which we feel have not sufficiently been addressed in the analysis to date. The Taskforce is not limited to the findings of the Investigation, and this report includes further evidence on pregnancy loss and neonatal care, where possible, for consideration.

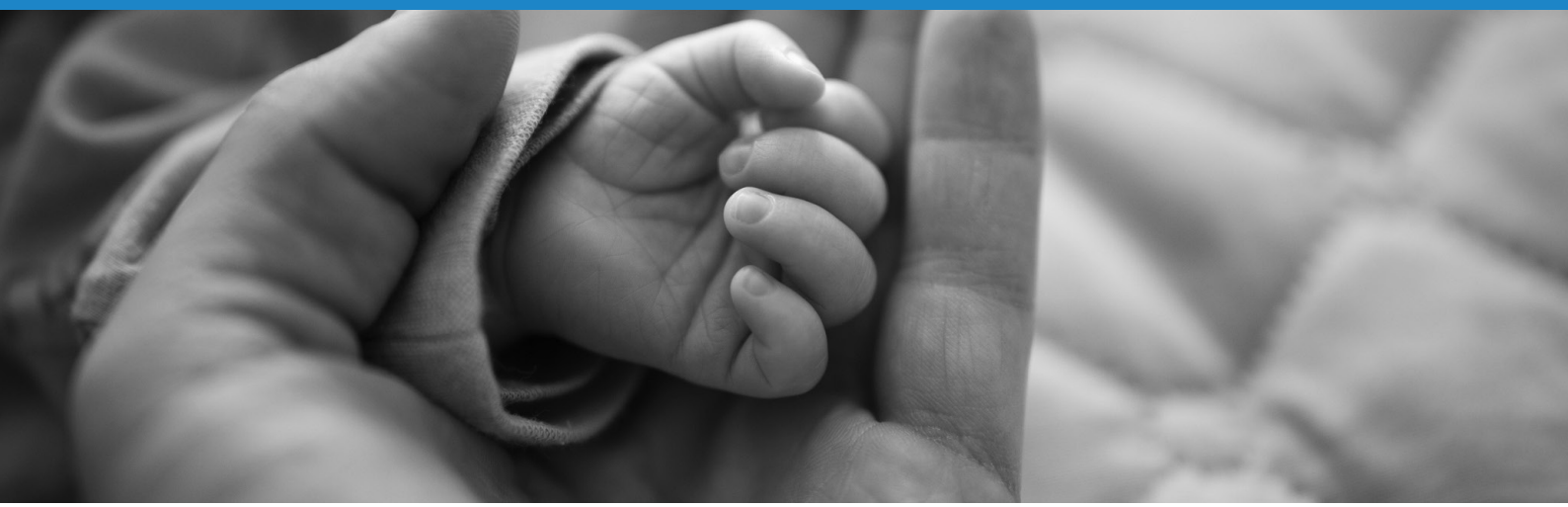
The questions included in the report will form the basis of the Joint Policy Unit's upcoming work, as we seek to address them.

Culture is an intangible concept that helps to explain why ways of thinking or behaving, positive or negative, are accepted and become the norm[1]. As such, it is threaded through each chapter as we consider how the five principles become embedded in the way maternity and neonatal services are delivered.

There is a unique window of opportunity to influence policy in England to make maternity and neonatal services safer and save more babies' lives. Recognising this, the focus of this year's report, and the data it contains, is on England. However, as the devolved governments in Northern Ireland, Scotland and Wales consider their own services, many of the questions posed would benefit from their consideration. To accompany this report and explore data across the devolved nations in more detail, we have published separate briefings which are available on our website. Key graphs are available on our data hub.

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





2. Safe

2.1. A shared understanding of safety

The National Maternity and Neonatal Investigation concluded that the maternity and neonatal[1] system needs urgent reform to put safety at its centre. However, our research has found that there is not a shared understanding of what 'safety' means (2). While safety is often understood as minimising harm (3), some have called for a more holistic definition which also includes patient experience and longer-term health and wellbeing (2,4).

There has been some debate as to whether safety has been prioritised at the expense of other aspects of quality of care (3), but rather than viewing safety as one dimension of quality, it should be seen as the foundation on which all decisions are made (5).

The Taskforce must first agree on a definition of safety and the metrics by which 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 (6).

Questions for the Taskforce

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

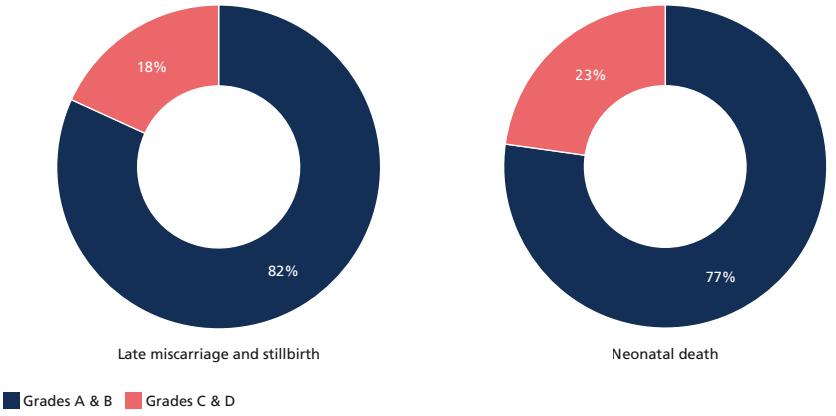
2.2. Reducing unwarranted variation in care

The Investigation found a fragmented system with significant variation in the care provided depending on location, the person receiving care (see Section 3), and the type of services provided (7).
Some variation may be acceptable – for example where care is tailored to the local population or patient preferences – but unwarranted variation may create safety issues (8). The Investigation found little evidence that variation had been consciously designed, based on evidence of what works or had been evaluated nationally.

Variation has an important impact on patient experience and clinical outcomes, particularly when care is not delivered in line with nationally agreed standards. According to data from local hospital reviews gathered via the Perinatal Mortality Review Tool (PMRT), one in six miscarriages, stillbirths and neonatal deaths reviewed across the UK may, or were likely to, have been affected by the care provided (see Figure 1).

1. As outlined in the introduction, the Investigation only considers neonatal care delivered within maternity settings (either in inpatient wards or in the community).

1 in 5 reviews following pregnancy loss or baby death found issues with the care provided that could have made a difference to the outcome.



Grade A represents reviews where 'No issues with care identified', and Grade B represents 'Care issues that would have made no difference to the outcome. Grade C represents reviews where Care issues may have made a difference to the outcome', and Grade D represents reviews where 'Care issues were likely to have made a difference to the outcome'. Data are from PMRT reviews in 2024. Source: PMRT (2025)

Figure 1. Proportion of PMRT reviews by grade in the UK, 2024.

Our research has highlighted several reasons for variation:

- **Lack of clarity over guidance:** the volume of guidance that exists means it is a challenge for health care professionals to remain abreast of the latest developments. Where multiple pieces of guidance exist, at both 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. In some cases, Trusts may come up with their own solutions to safety issues but often lack skill or the resources to do so (8). Guidance should include implications for workforce requirements, setting out the skills and competencies required to deliver them. Any mandatory standards should not be introduced unless they are fully funded.
- **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 interpreting services), there is a lack of agreed national standards and guidance.

Variation in safe and timely assessment by maternity triage

Women and birthing people are advised to contact their hospital's maternity triage department if they are concerned during pregnancy or early labour. However, our analysis of guidance from several Trusts found concerning levels of variation in advice around bleeding, waters breaking and reduced fetal movement (9). The absence of national guidance led Trusts to develop their own processes, resulting in women and birthing people receiving different advice and assessments depending on which services they contacted (10). This has led to the Care Quality Commission (CQC) raising concerns that "not everyone received a safe and timely assessment"(10).

The availability of staff plays an important role in the ability of triage to function well. The CQC found that many telephone and in-person triage services are inadequately staffed, leaving phone calls unanswered or women and birthing people waiting for a long time to be triaged (10).

Since the publication of our briefing, NHS England has published the National Maternity Triage Specification. The document sets out a national framework for maternity triage services, with agreed expectations on access, assessments, staffing, safety and performance monitoring. All of which aims to reduce variation between Trusts and improve safety to ensure women and birthing people receive timely and standardised assessments (11).

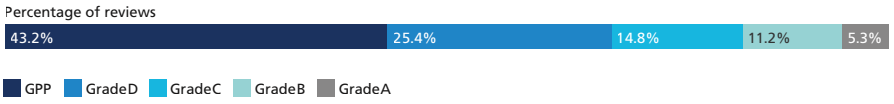
Whilst the publication of guidance is welcome, the document fails to include consistent, evidence-based information on when to contact triage, and it is unclear whether systems have, or will develop consensus on this. The guidance sets out the principle that maternity triage services must maintain safe and responsive staffing but does not include any funding to make this a reality.

The gestation of pregnancy also determines whether women and birthing people are able to access maternity triage rather than A&E, and this varies across the country. Women and birthing people who are unable to attend triage may be less likely to receive appropriate care.

We welcome the commitment from the new Health Secretary, Yvette Cooper, to re-introduce binding national maternity standards which set out core, mandatory expectations against which adherence could be monitored (12).

When developing mandatory standards, there must be a review of the current guidelines, how they were developed and their evidence base. A review of the existing Green-top Guidelines from the Royal College of Obstetricians and Gynaecologists (RCOG) found that 43% of recommendations rely on consensus and expert opinion, while only 5% were graded A (meaning that the evidence is categorised as the highest quality) (see Figure 2) (13).

Only 5% of RCOG existing Green-top Guidelines are developed from high-level evidence.



Source: Kumar et al (2026)

Figure 2. Proportion of Green-top Guidelines by grade, as reported by RCOG.

For a range of ethical and practical reasons, 'gold standard' research, such as randomised control trials, is not always possible in obstetric research (14). Current evidence also poses issues from an equity perspective, with Grade A evidence scoring poorly for equity considerations and expert opinion also being susceptible to bias (14). There is a need for agreement on what evidence is used to inform the standards, ensuring that equity is considered from the outset.

As well as evidence on the impact of standards, consideration must also be given to their feasibility and cost-effectiveness, which is all too often missing from current guidance (7). The resources required to deliver the national standards should be identified and must be fully funded.

Variation in perinatal care

Prematurity is a key driver of neonatal mortality, with around three quarters of neonatal deaths among babies born before 37 weeks in the UK (15). The National Neonatal Audit Programme (NNAP) monitors adherence to six 'optimal care' measures which it argues would contribute to reduced mortality and brain injury, if successfully implemented. However, the most recent audit found that only 1 in 5 preterm babies were found to have received all these measures (16).

There is significant variation in implementation of these measures between regions and neonatal units, especially in the administration of antenatal magnesium sulphate and ensuring extremely preterm babies are born in a centre with a neonatal intensive care unit (NICU) onsite.

Key drivers of variation included difficulties predicting preterm birth, unequal access to antenatal care, and clinicians' knowledge. Antenatal care offers the greatest opportunity to identify those who may be at higher risk of preterm birth. However, women and birthing people from deprived areas or marginalised groups tend to have delayed access to, and low engagement with, antenatal care, which may reduce health care professionals' ability to predict preterm birth. A cervical length ultrasound helps to assess the risk of preterm birth and is essential to enable in utero transfer, if required. However, access to equipment and trained staff can be limited out of hours.

To reduce variation and improve outcomes for preterm babies, the ability to predict and manage preterm birth must be prioritised. This must include improving access to antenatal care, especially for marginalised women and birthing people, and increased investment in staff training (17).

Questions for the Taskforce

- How will the national maternity standards be developed to ensure they incorporate the best available evidence?
- How can the national maternity standards allow sufficient flexibility for local population needs and patient preferences?
- What funding and resources are required to deliver the standards, and will this be provided?
- How should adherence to the national maternity standards be monitored?

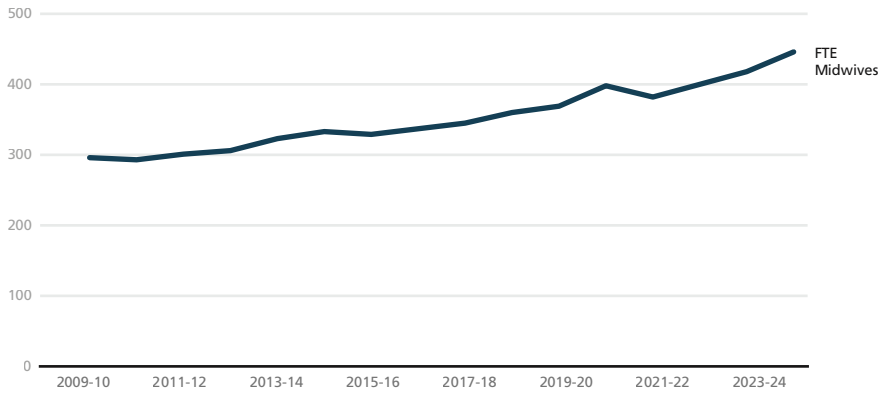
2.3. Safe staffing

In recent years, there has been debate about the extent to which workforce shortages are responsible for the systemic issues facing maternity services. There is currently no universally accepted definition of safe staffing or consensus on how many staff are needed in maternity services. We need to move the conversation beyond headcount to focus on whether we have the right people, with the right skills, in the right place, at the right time. This section focuses primarily on staffing in maternity services, reflecting recent JPU analysis which will be published later this year. We will publish further analysis of staffing in neonatal services in 2027.

2.3.1 Number of staff

In England, the number of maternity and neonatal staff relative to deliveries is increasing (see Figure 3 and 4). The number of midwives relative to deliveries increased 33.9% between 2014-15 and 2024-25, partly driven by falling birth rates, which have declined 16.2% in England and Wales since 2015 (18,19).

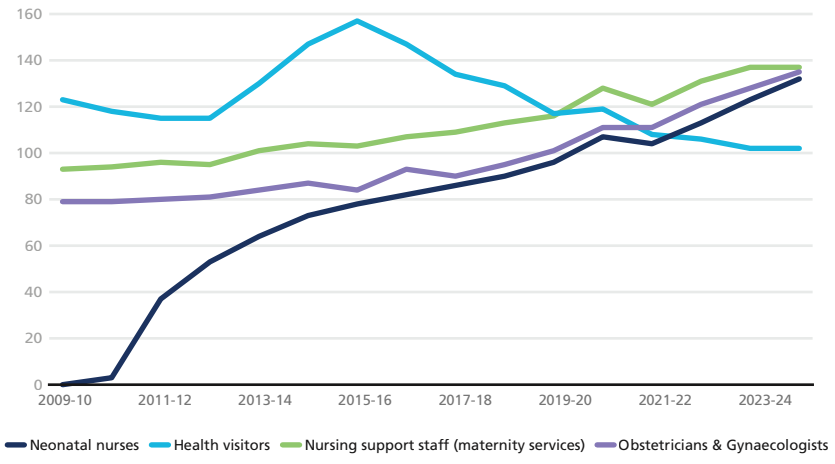
Apart from some variation during the Covid-19 pandemic, the number of FTE midwives per 10,000 deliveries has increased steadily since 2009-10.



Average annual full-time equivalent midwives working in NHS hospitals per 10,000 total deliveries in England. Source: NHS England (2025)

Figure 3. Average FTE midwives per 10,000 deliveries in NHS hospitals in England between 2009-10 and 2024-25.

FTE per 10,000 deliveries has increased among most maternity & neonatal staff groups since 2009, except health visitors.

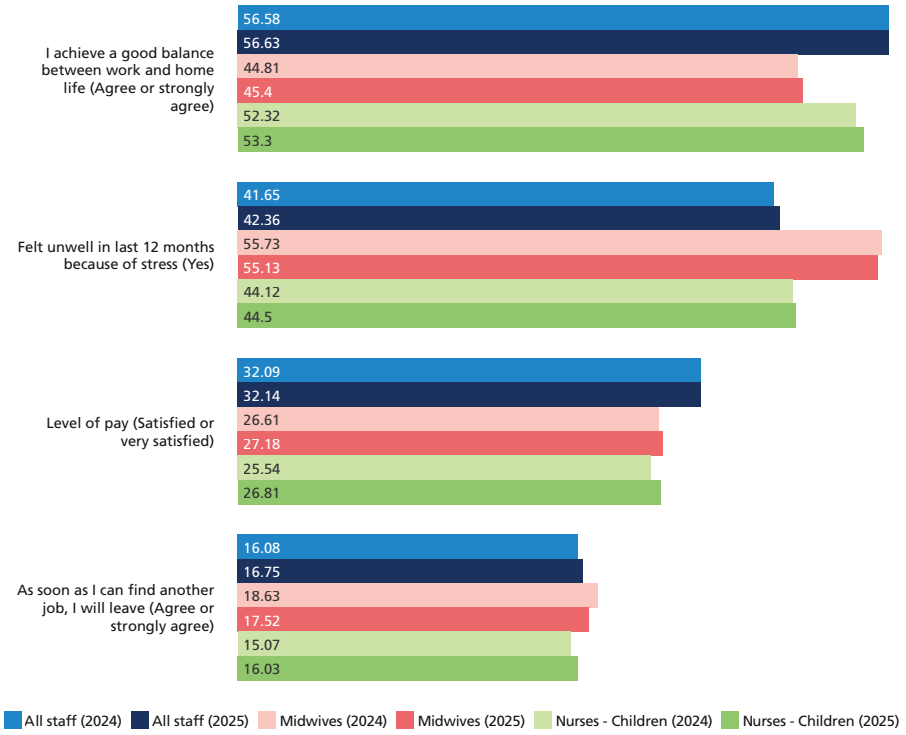


Average annual full-time equivalent health staff per 10,000 total deliveries working in maternity services in NHS hospitals in England. Midwives have been excluded for presentation purposes. Source: NHS Digital (2025)

Figure 4. Average FTE across roles in maternity and neonatal services per 10,000 deliveries in NHS hospitals in England between 2009-10 and 2024-25.

Despite the improvement in staff to delivery ratios, midwives continue to report high levels of stress and burnout[2] (see Figure 5) and sickness absence among midwives is higher than across all staff groups (see Figure 6).

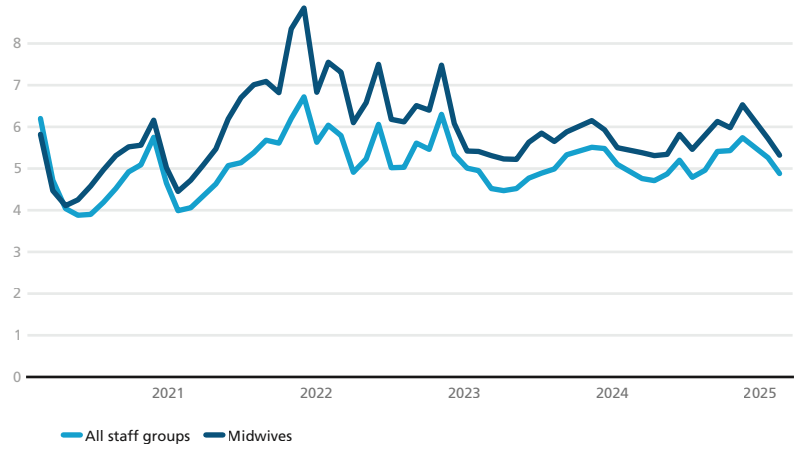
Responses to the staff survey are mostly more positive in 2024 compared to 2025, but midwives' satisfaction still falls below other staff groups.



Source: 2025 NHS Staff Survey (2026)

Figure 5. 2025 NHS England Staff Survey responses related to wellbeing and satisfaction.

Midwives sickness absences are higher than the all staff group average for the NHS.



A line graph showing the all staff groups average sickness on a monthly basis, compared to midwives. Source: NHS Digital (2025)

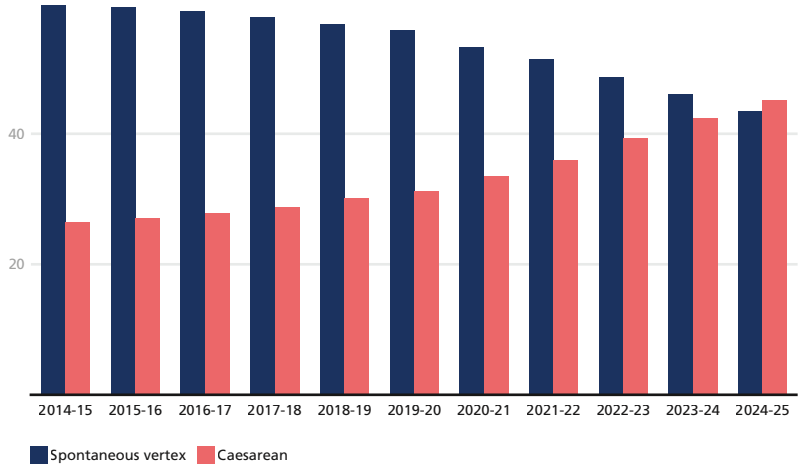
Figure 6. Monthly sickness absence rates for midwives compared to all staff groups, 2020-25.

While there are fewer births, many observe that maternity and neonatal care are becoming more complex (7). The mean age of mothers and birthing people has slightly increased, 0.3% each year, over the past decade and is 25% higher than 50 years ago (18,19). Pregnancy at advanced maternal age, which has increased by 6.4% in the past decade (18,19), increases the likelihood of multiple pregnancies, co-morbidities and pregnancy complications, which require more monitoring during pregnancy and increase the demand on staff time (20,21). Women and birthing people increasingly have long term physical or mental health conditions (including obesity, diabetes) or social complexities which may require additional, and often specialist, staff time to provide the necessary support and referrals.

2. Data for other staff involved in maternity and neonatal care are not disaggregated in the NHS Staff Survey.

Mode of birth is also changing, with an increase in caesarean sections and decline in spontaneous vertex births (see Figure 7). Caesarean sections typically require a greater number of multidisciplinary staff to support with the birth and postnatal care in comparison to spontaneous vertex births, although exact numbers vary based on local guidance and individual cases (22).

In the past decade, caesarean births have been increasing and are now more common than spontaneous vertex births.



Method of delivery in NHS Hospitals, 2014-15 to 2024-25 for spontaneous vertex and caesarean births. Source: Hospital Episode Statistics (2026)

Figure 7. Comparison of spontaneous vertex births and caesarean birth percentages between 2014-15 and 2024-25.

There have also been clinical and non-clinical changes which have impacted staff time. Best practice has evolved as new evidence has emerged, and there has been an expansion of non-clinical, administrative responsibilities.

Changes in the birthing population, clinical approaches, and administrative requirements affect all staff working in maternity and neonatal services. In England, the workforce planning tool BirthRate Plus is used for maternity services. However, this is limited to midwives and does not adequately reflect changing mode of birth and the changing clinical and administrative demands on staff time.

Early Pregnancy Units (EPUs)

Staffing levels and workforce planning standards are not publicly available for EPUs. Without more comprehensive and consistent data on pregnancy loss, it is difficult to determine the workforce capacity required to meet demand and deliver appropriate care. This limits the ability to assess whether current staffing levels are sufficient and to plan effectively for future service needs.

There is a need for evidence-based multidisciplinary workforce planning tools to accurately assess workforce requirements across services, staff groups and locations. Such tools would support a better understanding of how different professional groups work together to deliver safe, high-quality care that reflects the complexities of modern service delivery. Data generated through these tools could be analysed at local, regional and national levels to inform workforce recruitment and retention strategies and the funding required.

2.3.2 Staff skill and experience

The total number of staff alone does not reflect the skill and experience of the workforce. As well as having the right mixture of professional groups, services need a balance of skills and experience for the delivery of safe care and ongoing skill development of staff. For obstetricians, an RCOG workforce survey found that one-third planned to reduce their clinical sessions within the next five years, while 13% intended to retire and a further 19% were unsure (23). This raises concerns about the loss of experienced clinicians at a time when younger doctors are already expressing concerns about a lack of training opportunities.

Concerns have also been raised about the proportion of posts being filled by newly qualified midwives which is skewing the skill mix towards relatively inexperienced staff (24). Many out-of-hour maternity units are primarily staffed by junior midwives, with senior staff not being visible or active in clinical areas (7).

To deliver safe maternity and neonatal care, the workforce must be technically proficient, underpinned by high-quality training and education (8). Dedicated time for multidisciplinary training is important to ensure the workforce has the right skills and experience to carry out safe care. In Scotland, Health Boards must provide protected learning time for mandatory training, with 2% predicted absence allowance used for workforce planning (equivalent to 39 FTE hours per year). In the rest of the UK, time for mandatory training and continuous professional development is not ringfenced in practice and staffing pressures often mean learning and development is deprioritised to maintain safe rotas (25). A UK survey in 2020 found that over half of midwives had been called away from a mandatory training session in the past year (50.2%), with 'generally inadequate staffing' cited as the reason in over three quarters of cases, although staffing pressures may have been exacerbated by the Covid-19 pandemic (76.2%) (25).

The capacity to attend training is an issue across staff groups. A 2026 evaluation of the impact of anti-racism training found that obstetricians' and anaesthetists' ability to participate in training was often constrained by competing clinical demands and service pressures (26).

There must be agreement on what should be included in mandatory training and how much time that would take to complete. The multidisciplinary workforce planning tool should factor in the time required for mandatory training for all staff groups with some additional time for training based on local priorities.

2.3.3 Ways of working

Effective multidisciplinary teamwork, where staff collaborate, share concerns and problem solve, is essential to the safety of services. But despite a focus on improving multidisciplinary working, the experiences of women, birthing people and their families show that this has not yet been realised (7). Too often professional groups align to certain ideologies or assumptions which pit professionals against each other rather than focusing on the needs of women and birthing people (27,23).

Cohering around the common goal of delivering safe and equitable maternity and neonatal care is required in all multidisciplinary teams to build a healthy workforce culture (8). This requires leadership from Royal Colleges and professional bodies as well as clinical directors in Trusts. Reviewing how maternity and neonatal staff are educated could offer avenues to embed shared objectives and encourage multidisciplinary working from the outset of staff careers (28).

Questions for the Taskforce

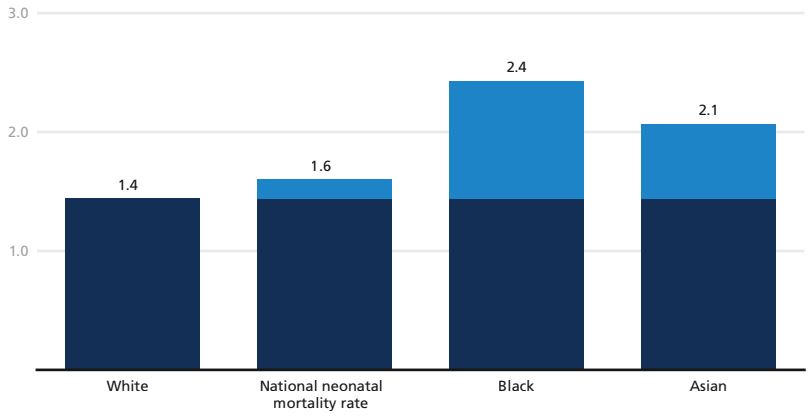
- How can multidisciplinary workforce planning tools be developed which accurately model the staff needed across services? Has this been done well in other services?
- How could education be reformed for professions working in maternity and neonatal services to embed multidisciplinary approaches?



3. Equitable

Inequalities in pregnancy and baby loss continue to persist in the UK. Babies from Asian and Black ethnicities and those born to mothers from more deprived areas were more likely to be stillborn or die neonatally. In 2024, the stillbirth rate among Black babies (5.6 per 1000 live births) was double the rate amongst White babies (2.7 per 1000 live births) (see Figure 8). The neonatal mortality rates for Black (2.4 per 1000 live births) and Asian (2.1 per 1000 live births) babies were 70% and 50% higher respectively than the rate amongst White babies (1.4 per 1000 live births). The neonatal mortality rate also increased 4.4% among Black babies in 2024, relative to 2023.

In 2024, neonatal mortality rates among Black and Asian babies were 70% and 50% higher respectively than the rate among White babies.



Neonatal mortality rate per 1,000 live births in the UK in 2024. MBRRACE-UK defines neonatal death as a baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born. Source: MBRRACE-UK (2026)

Figure 8. Comparison of neonatal mortality rates across ethnic groups in the UK in 2024.

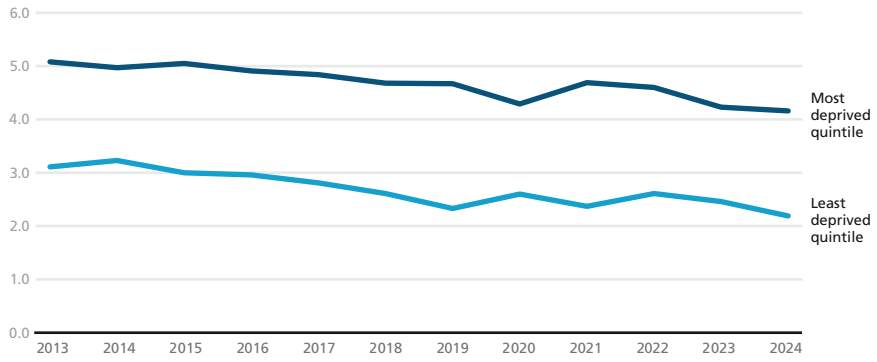
Rates of stillbirths and neonatal deaths in 2024 were also significantly higher for mothers living in the most deprived areas compared to the least deprived areas. The difference between the rates has also widened since 2023 (see Figure 9), driven by a decline in stillbirth rates among the least deprived. There are similar inequalities in the neonatal mortality rate, which is almost double among those living in the most deprived areas compared to the least.

Please see the Joint Policy Unit Data Hub to explore inequalities in perinatal mortality rates further, including changes in the rates over time and variation across individual ethnic groups.

The Investigation acknowledged that racism, discrimination and structural inequalities within the maternity and neonatal system impact the outcomes and experiences of women and birthing people (7).

When developing the national action plan, the Maternity and Neonatal Taskforce should set targets to eliminate inequalities in stillbirths, neonatal deaths and rates of preterm births between ethnic groups and socio-economic deprivation, against which the action plan should be evaluated. We have previously suggested a target to eliminate inequalities by 2035, to align with the government's 10 Year Health Plan (6).

The gap between the stillbirth rate in the most and least deprived areas has widened between 2023 and 2024.



Stillbirth rate per 1,000 total births in the UK. Deprivation is based on area-level socioeconomic deprivation which uses the mother's postcode of residence at the time of birth. Source: MBRRACE-UK (2026)

Figure 9. Changing UK neonatal mortality rates for the least and most deprived areas between 2013 and 2024.

Questions for the Taskforce

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

Eliminating inequalities will require action across the following areas:

3.1. Data collection and monitoring

Improving the quality and availability of data is vital to better understand the drivers of inequalities and inform interventions to reduce them. The Maternity and Neonatal Equalities Dashboard has been introduced to bring together key information to address inequalities (see Section 6.1). However, the insights are limited by quality and completeness of the underlying data.

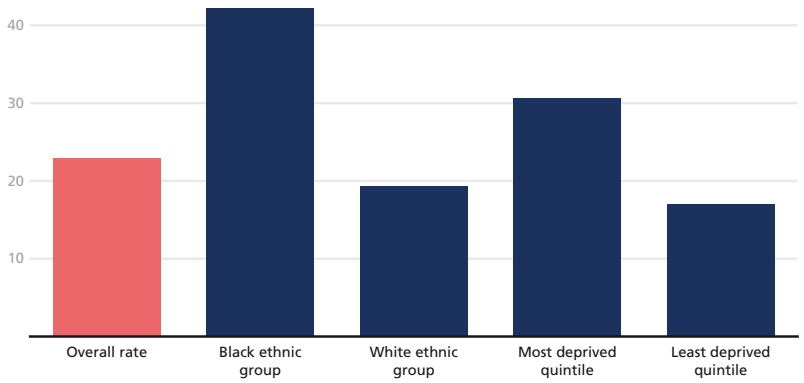
Ethnicity data within maternity and neonatal records are often not captured or recorded accurately, and the collection of data on social risk factors is limited. Key metrics related to social risk factors and protected characteristics that can feasibly be recorded must be urgently agreed upon and integrated into NHS systems. Improving data collection will require changes to digital databases and training for staff to understand the importance of collecting this data and methods to do so sensitively.

3.2. Accessibility of services

Improving data and insights is an important first step, but how the data are used is critical. The data must be used to identify barriers to accessing health services and services should be designed, with patient input (see Section 4.1), to improve accessibility. Improving access to high quality and culturally appropriate care is critical to reducing inequalities, with marginalised women and birthing people often experiencing the greatest barriers to care (29), resulting in poorer clinical outcomes. Timely access to antenatal, intrapartum, postnatal and neonatal services is critical to identify and manage complications and deliver personalised care. Where there is known family or maternal history that may impact on a pregnancy, consideration should be given to pre-conception assessment.

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 Black women and birthing people, as well as those living in the most deprived areas attended their first antenatal booking appointment after 10 weeks' gestation, compared to England overall (see Figure 10). The booking appointment involves an important assessment of needs and risks to identify whether additional care and support is required (particularly if there has been a previous loss or significant maternal morbidity), so late booking may impact pregnancy outcomes.

Booking appointment attendance after 10 weeks' gestation is higher for Black ethnic groups and the most deprived quintile compared to the overall rate for England.



Proportion of women and birthing people who gave birth to a singleton baby between 24+0 and 42+6 weeks who attended their first (booking) appointment with a midwife after 10+0 weeks of gestation. 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. Source: National Maternity & Perinatal Audit (2026)

Figure 10. Proportion of women and birthing people attending booking appointments after 10+0 weeks' gestation in 2024.

How services are designed and delivered, including how services are configured, health care professionals' knowledge, attitudes and behaviours, the inclusivity of training and guidance, and the provision of information can affect the accessibility of services. Inadequate provision of interpreting and translating services (see below) or previous experience of dismissive or discriminatory behaviour from staff, result in a lack of trust, engagement, and satisfaction with services and create barriers to access. Women and birthing people's circumstances may also create barriers, such as financial barriers, which service design needs to recognise and mitigate against. Research from Bliss found that more than half of parents surveyed (52%) said that costs impacted how involved they could be in their babies' neonatal care (30). These barriers are likely to vary across the population and across services and need effective data monitoring and parent engagement to identify and design solutions.

Translating and interpreting services

Several reports, including our research (31), have highlighted the inadequate provision of translation and interpreting services. Major challenges include inconsistent access to professional interpreters; reliance on family members, staff or online tools; and unclear policies for healthcare providers. Insufficient translation and interpreting services can lead to delays, misunderstandings and poorer health outcomes. Interpreting service failures have been linked to at least 80 cases of babies dying or suffering severe brain injuries in England, between 2018 and 2022 (32). While some maternity and neonatal services are taking steps to address these challenges, progress remains inconsistent. There is a need for much stronger national action, including the creation of centralised resources and commissioning guidance to ensure universal access to interpreting services (33).

Continuity of carer

The Investigation notes "continuity of carer is not a luxury — it is a clinical safety mechanism, and service design must reflect that" (7). Defined as a safety critical intervention, continuity of midwife has been found to improve women and birthing people's experience of labour and birth (34). This is especially true for women and birthing people at greatest risk of poor outcomes and experience, with Black women on continuity pathways having significantly lower rates of stillbirth compared to Black women receiving standard care (34).

Providing women and birthing people with a known midwife or point of contact has the potential to improve equity through the development of trusting relationships, increasing the recognition of social or clinical risk factors and allowing women and birthing people to feel more confident to disclose any concerns. Although trials have found that continuity of carer improves outcomes and patient experience (34), much of the evidence compares gold standard care provided through continuity of carer with business-as-usual care. Because of the resources required to implement continuity of carer in full, it is currently only recommended for underserved groups. Public reporting of who is currently receiving care and evaluation of outcomes is required to understand the impact of this policy and on whom.

Questions for the Taskforce

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

3.3. Racism and discrimination

Described as a fundamental driver of persistent ethnic inequalities, systemic racism may impact outcomes indirectly, by influencing socioeconomic and environmental exposures, or directly through implicit or explicit bias in the delivery of health care (35). Defined as a 'critical safety issue', the Investigation highlighted the urgent need to tackle racism and discrimination across services, with racialised assumptions contributing to women and birthing people feeling unheard, dismissed or excluded. As well as shaping how safe parents feel within maternity and neonatal services (30), stress from racism (both the incidents themselves and the vigilance needed to prepare for potential incidents) may increase the risk of adverse pregnancy outcomes, such as preterm birth (36).

The more recent roll out of the Perinatal Equity and Anti-Discrimination programme, commissioned by NHS England to tackle ethnic inequalities in maternal and neonatal care, aims to support perinatal services and improve outcomes by identifying local issues, strengthening leadership and embedding anti-discriminatory practices (37). However, an evaluation of the programme is needed to understand whether there were measurable improvements in organisational culture and patient experience, as well as a reduction in poorer outcomes by ethnic disparities. Training alone is unlikely to overcome racism and discrimination but must be coupled with greater accountability for individual behaviours as well as organisational culture (see Section 6) and active engagement with diverse parents to ensure meaningful improvements.

The recognition of the impact of racism on maternity and neonatal outcomes is welcome and the need to tackle it is urgent. However, further analysis is required to consider other forms of discrimination in addition to racism.

3.4. Inequalities linked to deprivation

As the Investigation noted, inequalities are also a result of social determinants of health, including poverty and socioeconomic disadvantages. A report into the inequalities linked to ethnicity and deprivation in neonatal care highlighted the 'double disadvantage' babies from minoritised ethnic groups and the most deprived communities face, including being more likely to need neonatal care, and experiencing poorer outcomes upon admission (30). Alongside disparities in treatment and care practices, such as lower likelihood of receiving deferred cord clamping, the report described barriers to parental involvement in neonatal care which are known to contribute to poorer outcomes.

Despite evidence of inequalities, there has been a lack of political focus on the issue. The Labour Party Manifesto committed to tackling maternal mortality inequalities for Black and Asian women, but not those linked to deprivation (38). Similarly, the Taskforce's Health Equity Expert Reference Group does not explicitly include anyone representing deprived areas. As well as being a priority in its own right, a greater proportion of babies of Asian Bangladeshi, Asian Pakistani and Black ethnicity groups are born to mothers living in the most deprived areas (15), meaning that addressing deprivation will also be important to tackle racial inequalities.

Part of the reason for the lack of focus on deprivation is the lack of a clear and consistently applied definition of deprivation that makes it difficult to understand what is being measured or compare findings. Current measures of deprivation are based on postcode as opposed to individual circumstances, and do not provide sufficient insight to guide policy. Individual-level data related to deprivation is collected in an ad hoc manner through maternity antenatal care appointments and there is a data gap nationally.

The Taskforce should provide leadership in this space, create a shared definition for the sector moving forward and ensure due consideration of inequalities by deprivation.

Questions for the Taskforce

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



4. Family-centred

Listening to women was the 'golden thread' of the recent Women's Health strategy (39). This echoes our review of reports into maternity and neonatal services, which highlighted 'failing to listen' as a key issue (40). Listening must include involving women, birthing people and partners in service design, using patient experience data to evaluate service performance (see Section 6), listening to women and birthing people's needs and preferences, and responding to individual concerns in real time and after harm has occurred.

4.1. Service configuration

Maternity care is currently provided in fragmented ways, with women and birthing people seen by many different professionals throughout pregnancy and birth (34). The impact of this fragmented care is cumulative with women and birthing people having to repeat their story, receiving variable advice, and missing opportunities for reassurance or escalation. This results in some describing 'task-driven' conversations with health care professionals rather than receiving individualised care across pregnancy, birth and, if required, neonatal care (41).

This is a system designed according to acute care capacity and requirements rather than how women and birthing people experience pregnancy, birth and the postnatal period, what services they need to access, and when.

The Modern Service Framework recommended by the Investigation is an opportunity for a fundamental service redesign that achieves high-quality care whilst prioritising safety and reflecting the needs of parents and modern society (7). Co-production should be a core principle to meaningfully involve women, birthing people and families in system design.

Maternity and Neonatal Voices Partnerships (MNVPs) are often used locally to feed parent voices into service design. To do so effectively, they require clear objectives and priorities, funding and resourcing, diverse group membership, ongoing training and good working relationships (42). So, while MNVPs may offer an avenue for co-production, these enablers need to be in place and cannot be assumed.

Questions for the Taskforce

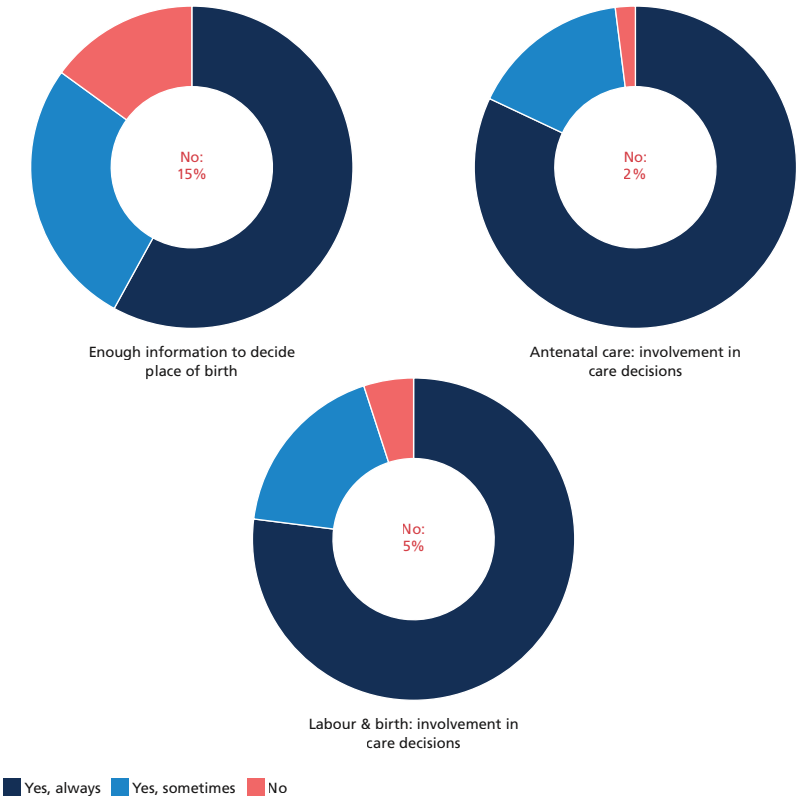
- What would a maternity and neonatal system designed for, and by, parents rather than health services look like?

4.2. Personalised care and informed choice

4.2.1. Unbiased, evidence-based information

Women and birthing people should be able to make informed decisions about their care – including about mode and place of birth – based on full, impartial information about all their options. Successive reports and surveys have highlighted how this is often not the case (see Figure 11). The Investigation also highlighted issues with staff not reading patients' notes, which document their needs and preferences, and information not being provided in a way that they could understand (8).

Parents did not always have enough information to decide the place of birth nor feel involved in care decisions.



Answers provided to the CQC Maternity Survey for questions b2, b11 and c16 respectively. Source: 2025 CQC Maternity Survey (2025)

Figure 11. CQC Maternity Survey results related to having enough information to make choices in England.

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"(7). Although there are no national data on the reasons that underpin decisions made around mode of birth (43) nor how frequently women and birthing people feel pressured to have a particular mode of birth, it has been identified as an issue in previous investigations at individual Trusts (44).

Patient experience surveys, such as the CQC Maternity Survey or the Patient-Reported Experience Measures (PREM), could provide an opportunity to gather data on women and birthing people's access to unbiased information and whether they felt able to make choices without pressure or influence. However, the CQC Maternity Survey does not include bereaved parents, and the PREM has not been piloted with bereaved parents. Updating the surveys so that they are suitable for bereaved parents, or running a dedicated survey, will be critical to ensure their perspectives are heard. The National Maternity & Perinatal Audit (NMPA) has also recommended mandatory data capture on the reason for interventions and, where applicable, the method and timing for induction of labour (43).

The Investigation is right to note that the focus should be on ensuring that women, birthing people and babies receive safe, high-quality care, and that their birth choices are listened to and respected. However, making that a reality requires a full understanding of the current barriers – including reviewing whether education, workplace culture and professional beliefs affect women and birthing people's ability to choose their preferred method of birth. The Investigation noted references to 'normal birth' in midwifery curriculum and the need for this language to be contextualised. However, it is not clear from the evidence whether this contextualisation is occurring. Reviewing how professionals are educated (see Section 2.3.3) may offer an opportunity to reframe or contextualise this language, breakdown any differences in professional beliefs and embed shared objectives. Professional standards should also be considered. The Nursing and Midwifery Council standards for proficiency for midwives are referred to as meeting the International Confederation of Midwives Essential Competencies for Midwifery Practice. These standards (last updated in 2024 and endorsed by the Royal College of Midwives) include a strong focus on promoting "normal" birth (45).

4.2.2. Enabling staff to deliver personalised care

Personalised care respects that women and birthing people may have different approaches to, and make different choices around, risk (46). Our research highlighted the challenge for staff when women and birthing people make choices outside of guidance. Midwives told the Investigation that they were left "holding risk alone, without sufficient guidance, support, or documented clarity about what was expected of them"(7). Staff must feel supported to deliver care based on women and birthing people's preferences. In some cases, delivering personalised care may require increased resources – for example, ensuring enough staff to run a home birth service (47) – or enough capacity for women to choose a caesarean birth if they wished.

Reports of staff not listening to women and birthing people's choices point, not only to capacity, but cultural issues of control and medical misogyny (48). Clinical leaders shape the culture in services and ultimately the care provided to women, birthing people and families (see Section 5).

Single Patient Record

Women and birthing people who have experienced pregnancy or baby loss, those with previous trauma or other additional needs often have to repeat their story each time they see a healthcare professional. The Single Patient Record (SPR) is attempting to overcome the fragmented information landscape to create a single health record, that can be accessed by both patients and health care professionals. This has the potential to be transformative for patient care and experience, with the right safeguards and effective implementation (49). In Estonia, e-Health records allow the public to access their own health data, provide service feedback and view aspects of how decisions related to their care were made (50).

Maternity has been identified as a priority area which will be used to test and develop the SPR. However, this is a longer-term project, with patients' access to complete data not expected until 2030. Improving how services listen to women and birthing people should not wait in the meantime.

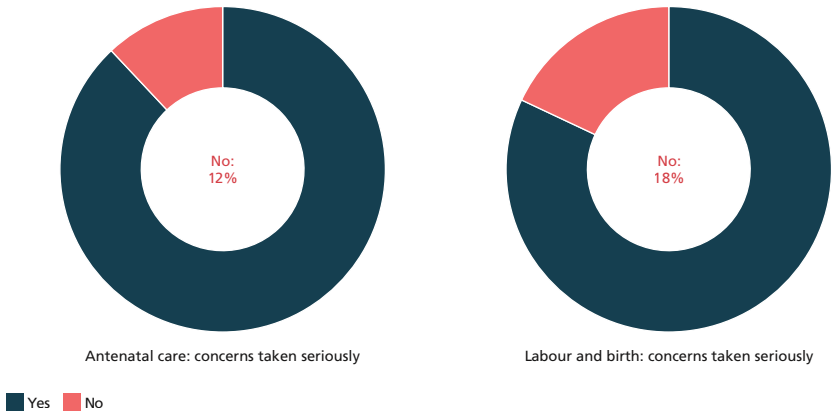
Questions for the Taskforce

- What data on personalised care and informed choice should be collected, and how?
- How can staff be supported to give women and birthing people unbiased information and deliver compassionate and respectful care in line with their choices?

4.3. Responding to concerns

Successive reports have highlighted the need to improve how healthcare professionals listen to parents in front of them in real time. The CQC Maternity Survey shows that nearly a fifth of women (18%) didn't feel like their concerns were taken seriously during labour and birth (see Figure 12).

Parents did not always feel their concerns were taken seriously during antenatal care, labour and birth.

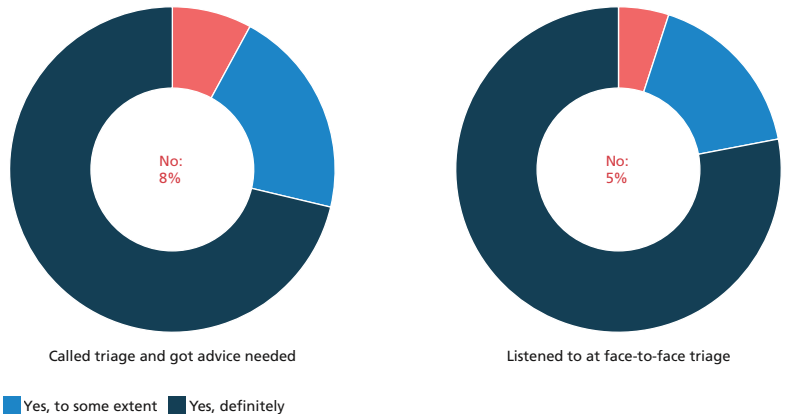


Answers provided to the CQC Maternity Survey for questions b15 and c12 respectively. Source: 2025 CQC Maternity Survey

Figure 12. CQC Maternity Survey results related to concerns during antenatal care, labour and birth in England.

The Ockenden review found multiple instances of women's concerns being dismissed, being advised to stay at home, leaving them scared and vulnerable, and not able to access the care they required (48). Our review of online advice on maternity triage highlighted variation in the information provided to women across Trusts in both the symptoms listed to prompt contact with triage services, and the language used for advice such as contractions (9). Nearly half of the Trust websites also included messages encouraging women to remain at home during early labour despite the evidence behind this recommendation remaining unclear. This inconsistent advice makes it harder for women and birthing people to know when to seek help, potentially discouraging them from raising concerns and contributing to delays in assessment and treatment. The CQC Maternity Survey has started to collect data on triage experiences, which found that nearly one in ten did not get the advice they needed from telephone triage or were not able to speak to someone (see Figure 13).

Parents were not always able to receive appropriate advice or weren't listened to during phone and face-to-face triage.



Answers provided to the CQC Maternity Survey for questions f2 and f3 respectively. The donut showing f2 responses (left) 'No' includes answers 'No' (6%) and 'Attempted to call but did not receive a response' (2%). Source: CQC

Figure 13. CQC Maternity Survey results related to receiving appropriate advice and being listened to in England.

Not listening to concerns may mean missed opportunities for escalation and action. In some cases, where these experiences directly contributed to harm or death, their trauma was compounded by the knowledge that they were not listened to, and action was not taken (7).

Questions for the Taskforce

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

Martha's Rule

In response to the Investigation and Ockenden review, NHS England has committed to rolling out Martha's Rule – which gives patients the ability to request an urgent review by an independent, specialist clinical team if they feel their concerns are not being listened to - across maternity and neonatal services (51). Martha's Rule may be particularly relevant in postnatal inpatient settings, where national survey data suggest women can experience difficulties accessing help and support when concerns arise.

The scheme has been piloted in 15 maternity and neonatal settings. Data are available for maternity and neonatal settings from June 2026; however, outcome data are not yet disaggregated publicly. Across acute services between September 2024 and June 2026, 60% of calls led to a change in treatment (13% of calls led to transfers of care and 47% led to other change in treatment) (52). Martha's Rule may give underserved families opportunity to raise concerns; acute deterioration calls have been highest in patients living in the most deprived areas (and a statistically higher proportion than the general inpatient population). However, calls were statistically lower among those with Black or Black British and Other ethnicity and higher among the White ethnicity group. Further work is required to improve awareness of the scheme amongst all groups, with targeted and culturally sensitive communication delivered in a range of formats (53).

Interim and in-depth evaluations have focused on acute care (53,54) and the policy has already been introduced nationally prior to rigorous prospective evaluation which complicates the interpretation of impact (55). Evidence of how Martha's Rule works in maternity and neonatal services is not yet publicly available and there are questions as to whether the scheme would solve the particular issues facing these services. Families advised to stay at home by telephone maternity triage would be out of scope of Martha's Rule, which is only available after hospital admission 56).

Some questions have also been raised as to how effective Martha's Rule may be in places where there is a toxic hierarchy (56). Staff may not be willing to contradict their colleagues where they feel unable to "challenge any of the things that are done within the unit" (7). The evaluation of Martha's Rule in acute services found that ward cultures and staff attitudes influence the adoption of the scheme and ultimately the identification of deterioration (53). It is also not clear where a second opinion would come from in smaller units. While the principles of Martha's Rule – listening to patients, flattening hierarchies and responding to deterioration – are widely accepted (55), this should not preclude the need to prove its impact on outcomes. While Martha's Rule may offer a process for escalation, without tackling the culture in units, the impact is less certain. Evidence of positive impact on outcomes in maternity and neonatal services, or at least of no harm, should be provided before NHS England invests resources into the roll out across all services.

Martha's Rule should also be viewed as a safety net, rather than a complete solution. The aspiration should remain that women, birthing people and families are listened to and any concerns acted upon at the earliest opportunity, without requiring formal escalation.

4.4. Reviews of deaths

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. To achieve this, the current system for reviewing baby deaths needs to be fundamentally restructured to centre bereaved families' needs. The review process needs to be improved and simplified, to give parents' perspectives equal weight with clinical records and embed learning.

The current review processes do not cover pregnancy loss at all gestational ages and are experienced by parents as overly complex, disjointed and difficult to navigate.

Families' evidence should be given equal weight to staff perspectives and clinical notes. Healthcare professionals have a legal and professional obligation, through the Duty of Candour, to be open and transparent with bereaved parents. However, clinical notes may be missing or inaccurate (48).

One suggestion is the creation of a single portal where parents can view all the information and reports in relation to their case as well as upload their own evidence. The Danish Patient Compensation provides an example, where all case information is held centrally and managed by 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. An equivalent approach in England could drive a more empathetic and human-centred approach, and support parents with their right to challenge inaccurate information. This centralised system could also provide an opportunity to update families with the actions taken because of the review(s), and any impact.

Questions for the Taskforce

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



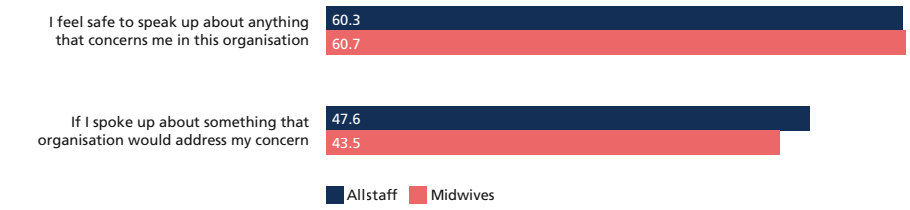
5. Accountable

A family-centred system is critical as ultimately providers of maternity and neonatal services should be accountable to service users. This means being responsible for actions that have been taken and decisions that have been made (7) to ensure the provision of safe and good quality care.

An accountable system must balance individual accountability with the organisational accountability for designing, delivering and improving systems (57). Trust Boards are responsible for the safety and quality of their maternity and neonatal services, but individuals within each Trust must also take personal responsibility for their own work. National and regional organisations are also responsible for external assurance that encourages, facilitates and rewards organisational responsibility (58,56).

In this section, we will consider each aspect of accountability in turn from individual to local and national. Threading through each layer of accountability should be the openness, transparency and a commitment to learning – sometimes known as a 'just culture' (59). It is clear from numerous reports that this is not the case currently in a system where staff feel unable to raise concerns or when they do raise concerns, they are not acted upon (see Figure 14). Trusts should be accountable to the families in their care but also the staff in their employment, to enable them to deliver safe care and respond to any concerns they raise.

Midwives feel less confident that their concerns would be addressed compared to all staff groups.



Proportion of NHS staff answering 'Strongly agree / Agree' to questions Q25e and Q25f on the NHS Staff Survey respectively. Source: 2025 NHS Staff Survey (2026)

Figure 14. 2025 NHS England Staff Survey responses related to raising concerns and confidence that concerns would be addressed.

Duty of Candour

All health care organisations and professionals have a legal and professional obligation to be open and transparent when things go wrong. However, the Ockenden review found uncertainty in the application of Duty of Candour (48). Duty of Candour applies when a notable safety incident – an unintended or unexpected event occurring during the provision of regulated care which has resulted in, or could result in, harm - has occurred. Meeting this threshold requires consideration of whether the care or treatment was unintended or unexpected. This can be particularly complex in maternity where adverse outcomes may occur, despite care being delivered in line with guidance.

5.1. Individual accountability

In a psychologically safe culture, staff can admit and apologise when a genuine mistake has been made, and an organisation can try to understand how to prevent similar mistakes occurring again. But rather than promoting openness and learning, the current system is characterised by fear and blame: where staff fear speaking out, unsafe care harms women, birthing people and babies, and families do not receive answers.

Individual accountability and system-based learning must go together. An investigation must consider how workload or cultural norms may have led to avoidable harm, as well as whether individual conduct requires scrutiny.

Most patient harm is because of unintentional errors, meaning that much of the policy focus has rightly been on the systemic issues in maternity and neonatal services (8). However, in her submission to the Thirlwall Inquiry, Mary Dixon-Woods refers to the distinctive form of patient safety risk from 'bad apples': individuals who behave in a grossly incompetent or unacceptable way. Rejecting a blame culture does not mean failing to address transgressive or unacceptable behaviour.

The Ockenden review described the impact of "long serving, powerful, dominating and some cases frightening individuals who set the tone and culture" (48). Individual behaviours, including racism and bullying, were not addressed which led to a toxic culture. While collective Board oversight is rightly scrutinised (see Section 5.2), the behaviour of individuals who make up the Board should be too. The Ockenden review found "Board members with insufficient curiosity to challenge", with individuals who were out of their depth. There was also a failure among some senior individuals in positions of authority to engage with the review. Only 28.6% of senior stakeholders from the former Clinical Commissioning Group (CCG), now the Integrated Care Board (ICB), participated in interviews, alongside just 53% of senior Trust staff.

The impact of the clinical negligence system

In 2025/26, obstetric claims accounted for 11% of clinical claims reported by volume[3] but accounted for 55% of the total value of claims. Clinical negligence payments related to obstetric claims amounted to £1.3 billion in 2025/26, 40% of the total value of payments (60).

The approach to clinical negligence in England is an 'outdated, arbitrary and scandalously expensive system' and there exists a 'stranglehold that lawyers exert over a system that should be putting the interests and needs of patients first' (61).

The current framework leads NHS Resolution, representing NHS provider Trusts, to take a defensive approach, which creates incentives for clinicians and managers to deny problems and puts the onus on families to establish negligence (7). This adversarial system is the antithesis of a just culture. It makes exchanges between families and professionals hostile and reduces opportunities for learning (28).

The early notifications scheme, which focuses on families affected by specific brain injury at birth, aims to enable earlier investigation, reduce legal costs, and accelerate learning. An evaluation will be published in 2026/27 (60).

Questions for the Taskforce

- How can the Department for Health / NHS England create a just culture to ensure individual and institutional accountability, promote learning and reduce adversarialism?

5.2. Trusts and ICBs

The safety and quality of maternity and neonatal services are the responsibility of the Board in each provider Trust. In 2023, we published a review of publicly available Board papers and minutes for seven NHS Trusts in England. We analysed whether the information presented to Boards, the process for review and actions taken, enabled Boards to deliver on this responsibility (62). This review highlighted issues in the quality and completeness of data presented to the Board, little scrutiny or discussion at public Board meetings, and a lack of action or follow up (which will be explored further in Section 6.1).

These themes were echoed by the Ockenden review and the Investigation. Scrutiny of maternity services was poor in Nottingham prior to 2020 – it was delegated to the Quality Assurance Committee, but key events were not escalated to the Board and its members lacked curiosity to seek out information (48).

While maternity and neonatal services have become increasingly visible at Board level, it is not clear that this visibility is leading to meaningful discussions (7). The Investigation found cases where reviews of death reports showing similar errors repeated over time were accepted by Boards without challenge. Echoing other reviews of maternity and neonatal services (40), the Ockenden review described a defensive and incurious culture at Board level, where criticism from external organisations was deemed to be largely unfounded and unfair (48). The Trust was failing to meet nationally set performance targets, such as A&E and cancer waiting times, which consumed a lot of Board attention and meant that maternity was not a priority.

3. Excluding General Practice Indemnity.

While individual Board members should be curious and open, their behaviour is influenced by the environment in which they operate. Trusts and services are over-saturated with recommendations and requirements. Organisations must make judgements about what requires action, and may choose to prioritise risks where there is an external imperative to do so – e.g. specific target or incentivisation, rather than complaints or soft intelligence (8). Employment rights are a legal obligation which drive human resource processes rather than patient safety (8).

Trusts are also constrained by the budgets provided by the Treasury and distributed through ICBs, who control NHS commissioning expenditure. Being presented with external responsibilities (such as targets) while lacking the resources and budget to meet them, can create pressures that lead to reactive and defensive rather than constructive behaviour (8).

Maternity Incentive Scheme

The Maternity Incentive Scheme (MIS) is a financial incentive scheme established by NHS Resolution to enhance maternity and neonatal safety within NHS Trusts in England. An evaluation in 2026 found that MIS has raised the profile of maternity and neonatal safety at Board level and compliance with the scheme's safety actions has improved (63).

However, the evaluation did not find any impact on maternity and neonatal safety outcomes, so it is not clear that Board attention is driving safety improvements (64). Compliance with safety actions is self-reported and the Ockenden review noted that compliance had "historically been asserted without sufficient scrutiny" and staff felt pressure to declare compliance despite known gaps (48).

5.3. National

Nationally, there are many organisations offering different forms of organisational, statutory, legal, professional, financial, public and relational accountability. These functions have evolved over time, often because of independent reviews and inquiries, and existing organisations have acquired additional responsibilities. This cumulative evolution has created a confusing and contradictory system (7) rather than one that has been designed holistically from the outset. The ongoing calls for a public inquiry show that some parents still do not feel that appropriate accountability structures are in place. Many of the systems of oversight and accountability are no longer fit for purpose (48) and now require a fundamental redesign.

The current system has the problem of "many hands" where services are answerable to a wide range of different regulatory agencies – over 100 organisations with a regulatory effect or influence according to a 2019 review (65) - whose requirements and recommendations may conflict, leading to confusion about what changes are required (8).

While some individual functions may operate effectively, many organisations have accumulated roles and responsibilities that can create tension with one another. For example, there is a fundamental difference between the CQC's two roles: identifying failing services to prevent patient harm and identifying where there is scope to improve performance (28). This has meant that it has not carried out either role effectively. There has been little evidence of improvement in poorer-rated maternity units following CQC inspections and ratings (66).

There has been insufficient scrutiny of the role and effectiveness of national oversight bodies, including NHS England and DHSC to date. While the Ockenden review noted that the CCG escalated concerns about the Trust to NHS England in 2020, analysis of the action taken because of this escalation was not included in the report. NHS England and DHSC also have a role in ensuring the safety of services by delivering on their obligations and acting in an open and transparent manner. There is a need for national leadership to synthesise reviews, recommendations and guidance, as well as provide the resources to deliver them. Asking services to deliver 24/7 access to maternity triage without additional funding to deliver it (11), for example, fails to recognise the issues facing services currently and sets them up to fail. NHS England's control over investigations into maternity and neonatal care has also led to the suggestion that it is focused on reputation management rather than learning and improvement (67).

The abolition of NHS England and its integration into DHSC creates a period of uncertainty but also presents an opportunity to review the existing governance, accountability, and oversight structures, and design a coherent, whole-system approach.

Maternity Commissioner

The recommendation to appoint a Maternity Commissioner offers an opportunity for greater oversight of the whole system, to connect the different forms of accountability together, and hold different functions to account (58).

To be effective, the Commissioner will require statutory independence, a dedicated team and protected funding, and relevant organisations should be required to respond to their findings.

As one of the key recommendations from the Investigation, Sands has called for a Commissioner-designate, supported by a transition team, to be appointed to work with the Taskforce.

Questions for the Taskforce

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



6. Evidence-driven

6.1. Acting on data and intelligence

Data and evidence must be central, to inform decision-making, identify safety risks early, and target resources where they can have the greatest impact. However, existing data and evidence sources are fragmented and do not always provide clear, actionable intelligence. Our review of Trust Board papers and minutes found considerable variation in the metrics reported to Trust Boards, as well as issues with quality and readability (62). Since this review, NHS England published a list of minimum measures that should be reviewed quarterly by Trusts which includes outcomes data, themes from reviews of deaths, staff and service user feedback and progress against the MIS safety actions (68). Some new tools have also been developed to standardise metrics and reporting. Evaluating tools and their use will be important to understand their impact on the safety of maternity and neonatal services.

For all measures and tools, quality and completeness must first be considered. For example, many tools and surveys which capture patient experience, such as the CQC Maternity Survey and the Patient-Reported Experience Measure, are not designed or piloted among bereaved parents who are excluded as a result.

Counting miscarriages

The number of miscarriages that occur each year in the UK are not systematically measured or reported. While some miscarriage-related data are collected across the four nations, coverage remains limited and does not provide a comprehensive picture of miscarriage prevalence.

There are opportunities to improve data collection and enable some reporting of miscarriage. These include:

- Improving how data are collected when women and birthing people have engaged with maternity services but later experience a miscarriage
- Considering how data could be collected from across all health services and from patients through the Single Patient Record
- Exploring the use of population surveys to develop populationwide estimates of miscarriage prevalence

For more detail, see our latest miscarriage briefing here.

Standardising inequalities data: Maternity and Neonatal Equalities Dashboard

Our previous review of Board minutes and documents found no discussion of data related to inequalities at Board level (62). This year, NHS England published the Maternity and Neonatal Equalities Dashboard which aims to make "health inequalities visible, measurable and actionable in maternity and neonatal services" (69). The Dashboard includes operational data, such as gestational age at booking and mode of birth, alongside data on service user experience and outcomes (stillbirths, neonatal deaths, maternal deaths, and preterm births); all measures are disaggregated by deprivation and ethnicity. The Dashboard aims to enable more targeted interventions and equitable support.

While the Dashboard addresses a gap in Board oversight by making inequalities and comparative performance data more visible, its impact depends on the quality and completeness of data (see Section 3.1), and how it is used to challenge performance, monitor trends, and oversee improvement actions.

Secondly, there are questions about how the data are used and by whom. Local, regional and national bodies should take a problem-sensing approach, using multiple sources of data and intelligence to identify emerging issues, rather than relying solely on metrics that may provide false reassurance (8). The Friends and Family Test is included as a minimum measure of patient experience but is all too often used to seek comfort rather than sense problems. One Trust pointed to positive Friends and Family Test results as a sign that the service had improved, despite an average response rate of only 3.9% over the past five years, according to our analysis (70).

Individuals also need an understanding of maternity and neonatal services to contextualise data and understand patterns and trends. We found that reports were often presented to Boards, without this additional layer or analysis and Board members themselves were not always directly engaged with services (62). In response, we have developed a guide to provide Board members with an overview of key data sources available.

The Investigation found examples in some Trusts where Board members and executive leaders engaged in regular, structured walkabouts of maternity and neonatal services to speak to families and staff about their experience and perspectives. This type of soft intelligence cannot be captured in a tool but provides vital insights into the safety of services.

Finally, much of the focus has been on how data and evidence are used by Trusts. Evaluations should also consider how data and evidence are used by regional and national organisations.

Differentiating safety signals from noise

The Independent Investigation into maternity and neonatal services in East Kent also highlighted the challenge Trusts and regional and national organisations face in differentiating between significant safety signals and random "noise" in the data (71).

In response, the Maternity Outcomes Signal System (MOSS) was developed by NHS England to detect unusual patterns in routinely collected intrapartum outcome data. MOSS tracks whether there are more adverse events than expected, issuing an amber (95% chance that the increase in events is real and not due to chance) or red (99% that the increase is real and not due to chance) alert. MOSS automatically emails registered users from Trusts, ICBs, and regional and national leadership when a signal occurs and triggers a rapid safety check which should be completed within eight working days, with actions shared with regional and national teams.

If accurate, MOSS offers important support to Trusts to identify real safety issues. However, as with all tools, its impact will depend on how effectively it works, how it is used and what mitigating actions are implemented as a result. MOSS only includes deaths among term babies so it will not pick up higher than expected deaths among preterm babies (who account for the majority of neonatal deaths). Further detail is also required on how the 'expected' deaths are calculated to ensure that large Trusts in particular are able to differentiate between signals and noise due to the greater proportion of babies with serious congenital malformations who are delivered there.

Trusts are now required to access MOSS and the MBRRACE real-time data monitoring tool at least monthly. However, these tools cannot determine the extent to which users engage with them, and compliance with the monthly requirement may not reflect genuine usage (as opening and closing the tool would still count as a 'view'). Evaluation should also consider regional and national oversight of MOSS and what actions are taken if Trusts do not respond to safety signals or engage meaningfully with the tool.

Questions for the Taskforce

- What are the critical data gaps in maternity and neonatal services and how can they be met?
- How effectively are current tools and processes used (locally, regionally and nationally) to review data and evidence regarding the safety of services?

6.2. Evaluating what works

The initiatives, tools and processes that have been introduced in response to concerns about the safety of services often lack a strong evidence base or have weak or non-existent evaluation. Expertise, engagement with families and staff, time and capacity to develop, test and deliver recommendations are often significantly underestimated, compounded by a lack of rigorous evaluation (8).

A renewed evidence-driven approach to improving the safety of maternity and neonatal services must ensure changes or initiatives intended to support improvement are rigorously evaluated. Evaluation considerations must be integrated into the design of interventions to ensure appropriate data are available to understand impact. Without robust evaluation, there is a risk that initiatives become embedded in practice despite limited evidence of effectiveness. This reduces opportunities to direct resources towards interventions that would demonstrably improve outcomes.

Questions for the Taskforce

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

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