Submission to the National Maternity and Neonatal Investigation in England

Sands & Tommy's Policy Unit

Working together to save babies' lives

Sharing insight and evidence from the Sands and Tommy's Joint Policy Unit

- The Sands and Tommy's Joint Policy Unit is focused on achieving policy change that will save more babies' lives during pregnancy and the neonatal period and tackle inequalities in pregnancy and baby loss, so that everyone can benefit from the best possible outcomes. We are making this submission to support the Independent Maternity and Neonatal Investigation currently being undertaken in England.

- A key finding from our recent work is that - while there is widespread agreement on the need for change to improve the safety of maternity and neonatal services - there is not clear agreement on what that change looks like. The investigation must build consensus on what safe care looks like and set out a clear policy approach for achieving it, with responsible organisations held accountable for implementation.

- To measure progress on the safety of maternity and neonatal services we have called for the establishment of new targets to improve birth outcomes. These should be focussed on matching the best-performing countries in Europe for maternity and neonatal outcomes and eliminating inequalities.

- The evidence and insight provided below is structured according to the terms of reference for the investigation, and we have provided links to sources of information which the investigation team may find useful. A collection of key data on maternity and neonatal services can be accessed on our Data Hub.

Understanding lived experience

- It is welcome that the investigation is committed to understanding the lived experiences of women, babies and families at all stages of the maternity and neonatal care pathway, hearing directly from those individuals. There must be a commitment to effective engagement throughout the process, including the implementation of any recommendations. Too often, service user engagement is seen as a single event rather than a continuous process.

- Our recent survey of service users and staff regarding the safety of maternity and neonatal services highlighted areas where greater consensus was required. This includes a shared understanding of what is meant by 'safety', a comprehensive analysis of staffing requirements, and exploring the perceived tension between adherence to guidance over personalisation of choice.

Reviewing quality and safety of maternity and neonatal services

Creating a shared understanding of safe care

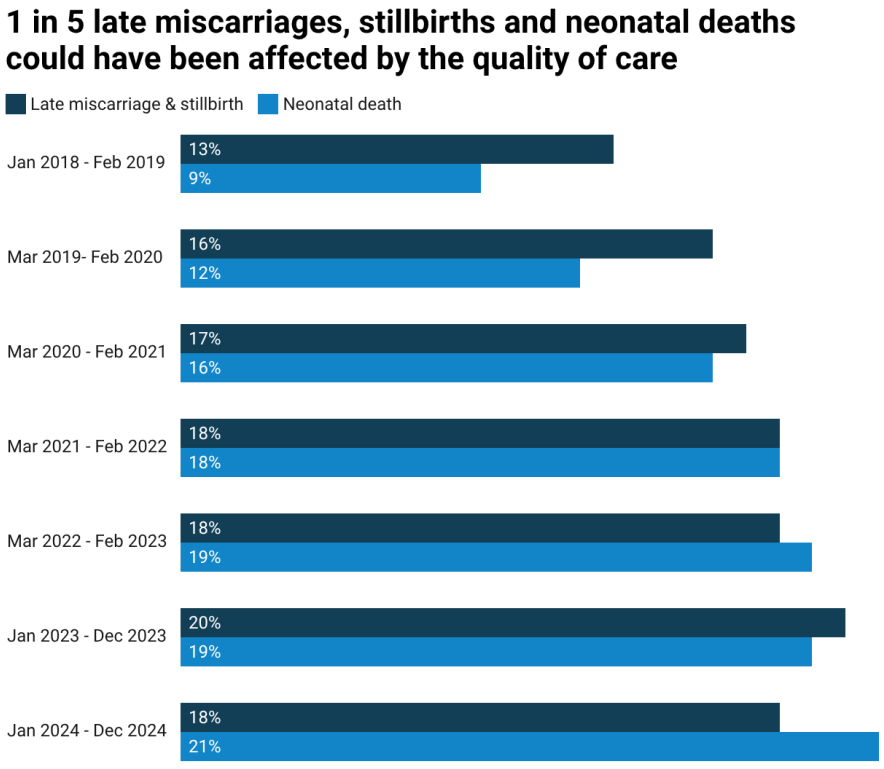
- While there is widespread agreement on the need for change to improve the safety of maternity and neonatal services, there is not agreement on what that change looks like.

- Through our recent call for evidence on the safety of maternity and neonatal services, it was evident that there is not a shared understanding of what is meant by 'safety'. Some interpreted this as improving outcomes, with a focus on reducing preterm birth and perinatal mortality, while others focused on ensuring pregnant women and birthing people have a positive experience.

- There is a role for healthcare organisations to build consensus on what the key elements of a safe system are. The response from some professional bodies has focussed on staffing levels, which ignores many other issues facing services. To make meaningful progress we must move beyond just talking about numbers of staff to define what a safe system looks like, and the staff needed to deliver it.

Reducing variation in care to prevent avoidable deaths

- According to data from the Perinatal Mortality Review Tool (PMRT), 1 in 5 late miscarriages, stillbirths and neonatal deaths could have potentially been prevented with better care. As highlighted in our annual Saving Babies' Lives Progress Report, too often babies are dying because of care that is not in line with nationally agreed standards. To make progress we need a national focus on addressing unwarranted variation.



Based on the proportion of reviews graded C/D: "Issues with care may/likely affected outcome". Based on reviews from across the UK. Data for stillbirths only include care during pregnancy while neonatal deaths include pregnancy, birth and neonatal care. PMRT uses the most serious grading at any stage of care for the overall neonatal care grading.

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Chart: Sands & Tommy's Joint Policy Unit • Source: PMRT (2025) • Created with Datawrapper

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

Reforming reviews of baby deaths

- The system is not properly learning lessons when babies die or listening to the experiences of bereaved families to improve care in the future.
- Bereaved parents want answers about why their baby died and, where relevant, action and accountability. To achieve this, the current system for reviewing baby deaths needs to be fundamentally restructured to centre bereaved families' needs and embed learning.
- The review process must be simplified and improved to better enable parents to engage, should they want to.
- The current systems for reviewing deaths are complex with unclear thresholds for local and national processes. Some deaths may go through multiple reviews (e.g. PMRT, MNSI) which are disjointed and do not share findings with each other. Reviews rely on clinical notes with limited opportunities for parents to feed in their perspectives or challenge findings. Although healthcare professionals have a legal and professional obligation to be open and transparent with bereaved parents, as determined by the Duty of Candour, this is not the reality experienced by many.
- Reports of missing or inaccurate notes or reviews, which justified rather than explained sub-optimal care, reveal an opaque and defensive system rather than one focused on learning and improvement.
- Review processes can often be lengthy which may add to or prolong the trauma experienced by parents. Some women and birthing people may become pregnant again before these processes have concluded so any information that may support a subsequent pregnancy may be too late.
- One suggestion is the creation of a single portal where parents can view all the information and reports in relation to their case and upload their evidence. In Denmark, Danish Patient

Compensation gathers all documents relevant to a case in one place and assigns an individual case worker. Having centralised information and one point of contact could support families to understand the review process(es), share their perspectives and challenge findings, if required. A case worker could drive a more empathetic and human-centred approach and support parents with their right to challenge inaccurate information.

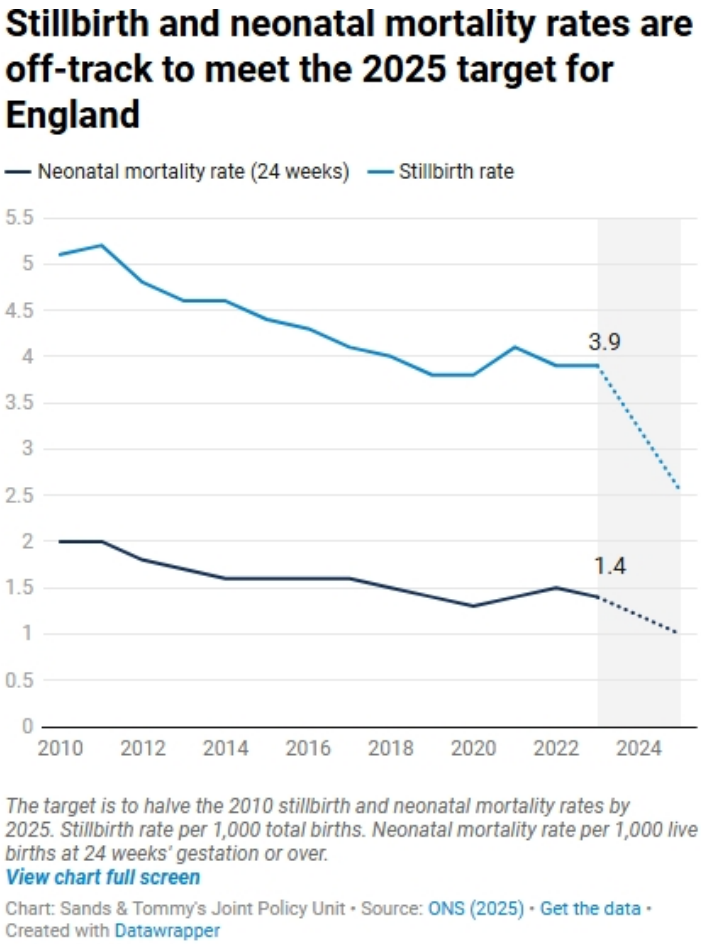
Integrating learning from reviews into service delivery

- Learning from reviews must lead to improvements in service delivery. Reviews should focus on systemic issues and ensure that recommendations are informed by parental engagement, genuine and open reflection on what went wrong from staff and independent scrutiny.
- Staff time must be ring-fenced to reflect on deaths in their maternity and neonatal services, implement recommendations and provide external oversight for other Trusts.
- Current reviews suggest actions, but there is little oversight of their implementation. National, regional, Trust, and frontline services' leadership must all play a role in a cohesive and joined up system to ensure accountability for implementation.
- Trust boards should take a more active role in monitoring the implementation of recommendations and understanding their impact. Local Maternity and Neonatal Systems and national bodies should identify frequently occurring recommendations (regionally and nationally respectively), the level of implementation (or barriers to doing so), and the overall impact. Finally, there must be a system for updating bereaved parents with the actions that have been taken.

Improved birth outcomes should be the measure of safer care

- The National Maternity Safety Ambitions – which aim to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries and reduce the rate of preterm births from 8% to 6% - were introduced to drive action to make maternity services safer in England. A decline in mortality rates in England since 2010 suggests an overall improvement in safety across services.

- However, initial progress to reduce rates of stillbirth and neonatal death has stalled, with little change in the rates over the past few years. It is all but certain that the government will not meet the National Maternity Safety Ambitions, which expired in 2025 (and will be reported in 2026), suggesting a lack of effective national oversight of the changes required.



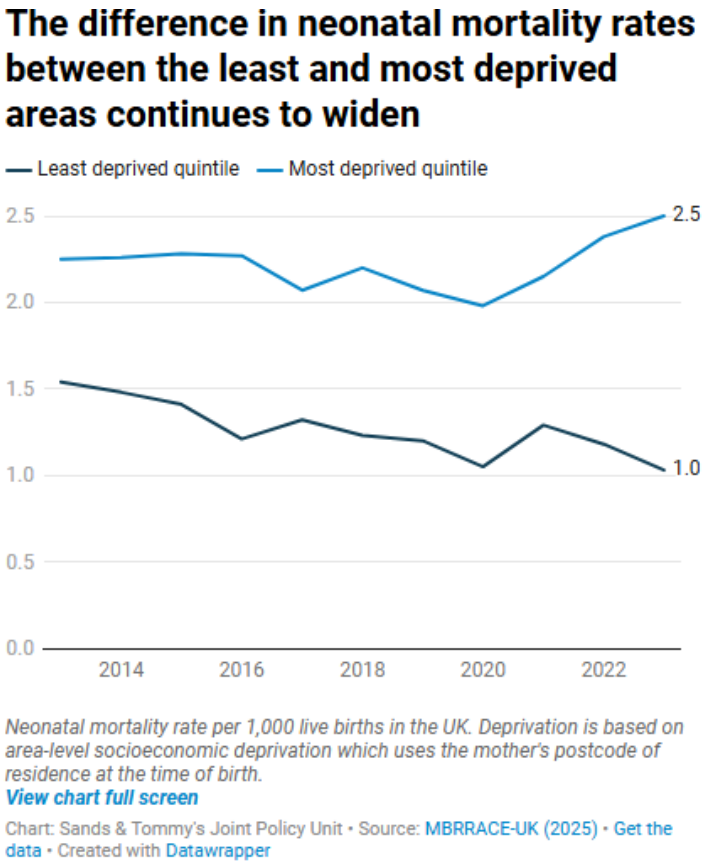
- To measure improvements in the quality and safety of maternity and neonatal services we believe that the government should set new ambitions for reducing perinatal mortality – focused on matching the best-performing countries in Europe. We propose the following ambitions, with a deadline of 2035 to align with the 10 Year Plan for the NHS in England:
    - A stillbirth rate of 2.0 stillbirths per 1,000 total births.
    - A neonatal mortality rate of 0.5 neonatal deaths per 1,000 live births for babies born at 24 weeks' gestation and over.
    - A preterm birth rate of 6.0%, with disaggregated data for iatrogenic and spontaneous preterm births.
    - Eliminate inequalities in these outcomes based on ethnicity and deprivation.
    - Establishing routine data collection on miscarriages should be prioritised. Once established, an ambition to reduce the miscarriage rate should be added.

Identifying drivers and impact of inequalities

- Inequalities in pregnancy and baby loss persist across England, with stark disparities around ethnicity and socioeconomic deprivation.

- Babies from Black and Asian ethnic groups face higher rates of stillbirth and neonatal death when compared to White babies. 2023 data from MBRRACE-UK shows that despite a decline in stillbirth rates for Black and White babies, there was a sharp increase for Asian babies. Black babies are still 2x more likely to be stillborn when compared to White babies. Furthermore, the

gap between neonatal death rates in the most and least deprived areas of the UK continues to grow.



- Improving the quality and availability of data is vital to better understand the drivers of inequalities and inform interventions to reduce them. Ethnicity data within maternity and neonatal records are often not captured or recorded accurately, and the collection of data on social risk factors is also limited. Key metrics related to social risk factors 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.

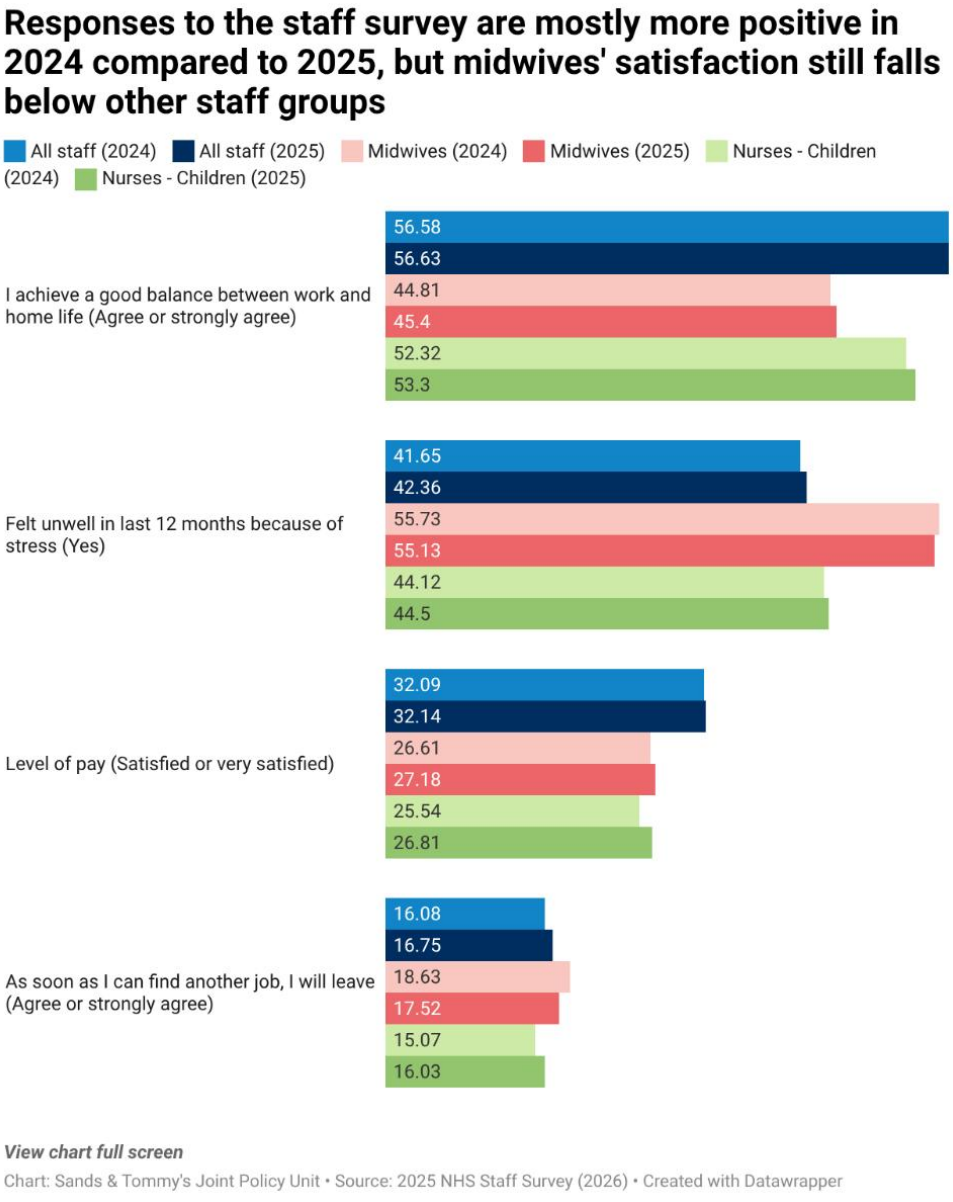
- While better data is needed for a more nuanced understanding of the drivers of inequalities and to inform a comprehensive, cross-government approach, the government and health organisations do not need to wait to act. We already know that women and birthing people from minoritised backgrounds and areas of higher deprivation experience worse health outcomes because of poorer access to care and experiences of racism and discrimination. Health services must pilot interventions to improve the accessibility of services and evaluate their impact.

- Any approach to tackling inequalities must ensure equitable access. Several reports, including our research, 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. 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.

Understanding the experiences of staff and healthcare professionals

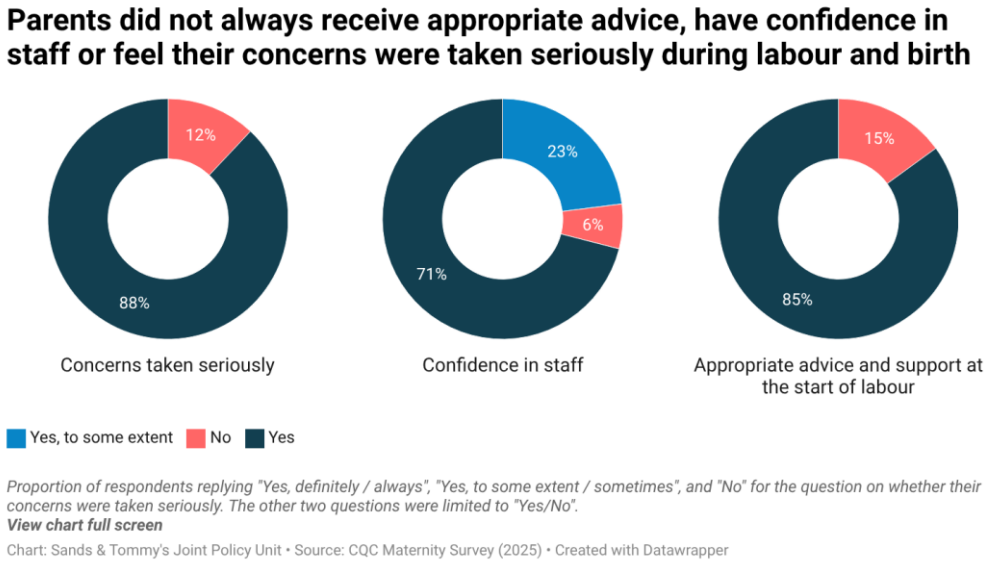
- As highlighted in our Saving Babies Lives' 2025 progress report, surveys of staff and patients point to a stressed and undervalued workforce.



- According to a 2024 RCM survey of midwives experiences, 74% said they always or too often faced unrealistic time pressures or workloads; 64% said they felt burnt out or exhausted at the end of most or all their shifts; 26% reported feeling burnt out or exhausted at the end of every working day; 87% said their maternity units were not staffed safely in the week of the survey.

- The 2024 Darzi report into the NHS noted that high levels of pressure and stress are contributing to poor morale, burnout, sickness absence and the loss of trained staff.

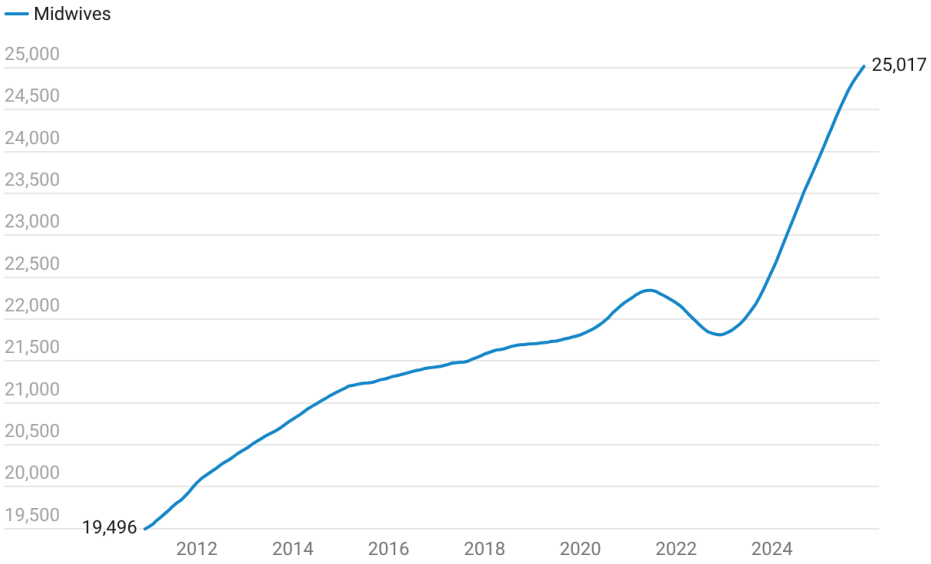
- These staffing pressures are also reflected in the CQC maternity survey results. Over the past five years, perceptions of staffing availability have worsened. Compared to the results from 2018, fewer respondents were able to see or speak to a midwife as often as they wanted after their birth, and more were left alone during or shortly after birth, at a time that worried them. One in four respondents (23%) reported that they were not always involved in decisions about their care.



Staffing levels

- Despite the staffing pressures outlined above, the number of full-time equivalent (FTE) midwives has been increasing. The figure below illustrates a sharp and sustained rise in the number of FTE midwives in England, as recorded by NHS Workforce Statistics highlighting a 15.4% increase from March 2023 to December 2025. December 2025 shows the highest level of FTE midwives on record at 25,459.

12 month rolling average of the number of midwives (FTE) employed in the NHS in England



There is a general trend of increase of FTE midwives over the past 15 years, with a sharp increase in 2023, following a drop in 2022. This data show a 12-month rolling average of FTE midwives each year, from the time period of December 2010 to December 2025.
View chart full screen

Chart: Sands and Tommy's Joint Policy Unit • Source: NHS Workforce Statistics (2025) • Created with Datawrapper

- However, increasing clinical complexity and changing clinical and administrative requirements on midwives' time must be factored into staffing analysis. Specialist roles for midwives and neonatal nurses, including bereavement and safeguarding roles, are not always replaced, leaving clinical teams short-staffed or specialists being pulled back to frontline care provision.

- Data on the overall number of midwives also does not capture the skills mix of the workforce including the level of experience and specialisms among midwives as well as the staffing level of other professional groups delivering maternity and neonatal services.

- There are divergent views on the extent to which workforce shortages are responsible for the systemic issues within maternity and neonatal care. As discussed in our call for evidence, discussions on the maternity workforce need to move away from a binary debate on whether we do or do not have enough staff to instead focus on the staffing requirements needed to deliver safe care. This should include a proper assessment of maternity and neonatal services' capacity and demand, including the changing health profile of the birthing population, declining rates of spontaneous birth, time for training and supervision, and the creation of specialist or managerial roles.

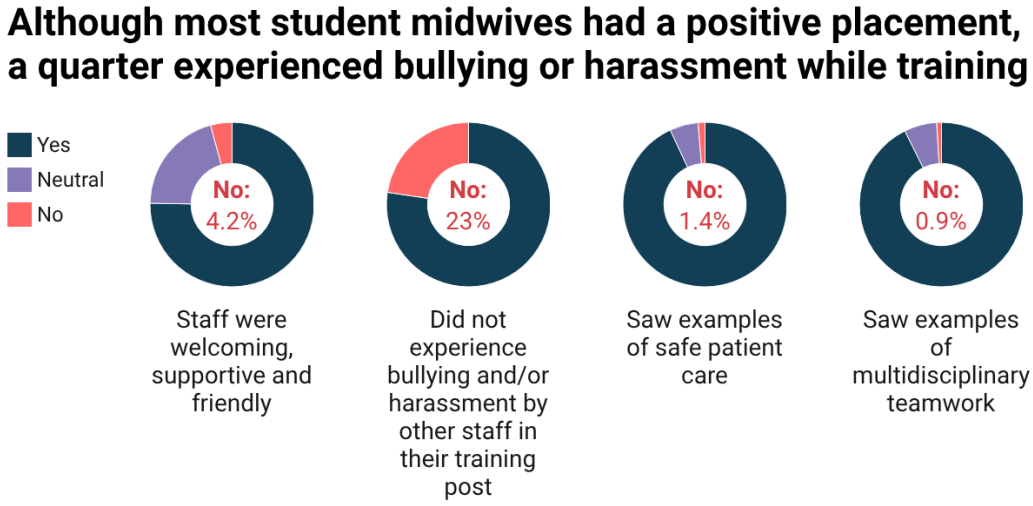
- Workforce modelling must move beyond large staff groups (such as midwives) to consider the workforce requirements across all groups and how to support multidisciplinary teamwork.

Organisational culture and leadership

- Previous reviews and investigations have highlighted the lack of safety culture within services, which results in a workforce that feels unable to escalate concerns about clinical care. This may be due to fear that they will be blamed or punished for reporting incidents, or because of

hierarchical structures that prevent junior colleagues from challenging decisions from senior leaders.

- Bullying and harassment undermine the psychological safety for staff and affects teamwork and communication. In 2024, issues of bullying were raised by student midwives in the National Education Training Survey, with a quarter of students reporting experiencing bullying or harassment by other staff while training. Of those who experienced bullying or harassment, only 14.3% reported it.



- Creating an open learning culture must be led from the top. Boards must embed a culture of curiosity and learning rather than focusing on compliance and reputational management. A review of national initiatives, such as the Maternity Incentive Scheme, should evaluate whether they have delivered an increased focus on safety, or have had unintended consequences.

Examining the response of healthcare organisations

- We have highlighted below how a lack of accountability and leadership has limited the implementation of recommendations from previous reports into maternity and neonatal safety. Despite repeated acknowledgement of the problems in maternity and neonatal services, this has not been matched by the actions and responses of healthcare organisations nationally.

National leadership to improve the safety and quality of services

- There must be clear national leadership for the safety and quality of maternity and neonatal services, especially in light of the abolition of NHS England and the integration of its core responsibilities into the Department of Health and Social Care.

- Despite numerous attempts by NHS England and the Department of Health and Social Care to respond to recommendations from past reports and reviews, safety and quality concerns continue to persist. It is all but certain that the government will not meet the National Maternity Safety Ambitions, which expired in 2025 (and will be reported in 2026), suggesting a lack of effective national oversight of the changes required.

- A stronger national leadership with clear accountability for the delivery and oversight of progress, including the prioritisation and sequencing of recommendations from multiples inquiries, is urgently needed to make progress.

- NHS England has often pointed to their perinatal culture and leadership programme as a solution to existing issues with culture, leadership and teamworking. However, an external evaluation from the University of Birmingham found 'limited evidence' of change within services, and a failure to spread learning across the system, suggesting that the programme is not working as intended. It is vital that systems create a culture that encourages staff to share and escalate concerns, without fear of retribution.

Board oversight of maternity and neonatal services

- The safety and quality of maternity and neonatal services are the responsibility of the board in each NHS Trust. However, board oversight has been highlighted as an issue in successive inquiries and reviews.

- We reviewed publicly available board papers and minutes for seven NHS Trusts in England to analyse whether the information presented to boards, the process for review, and actions taken enabled boards to deliver on this responsibility. Our findings across these three areas raise questions about a boards' ability to have a full understanding of the performance of maternity and neonatal units under its direction. The full paper is available here.

- There must be greater support for frontline staff to improve the quality and consistency of reports shared with the board (including guidance on minimum metrics that should be included and examples of good practice), as well as support for board members to help them to contextualise and interpret the information that they receive.

Understanding the impact of specific professional beliefs

- Past reviews have consistently highlighted the negative impact of specific professional beliefs on the safety of services – specifically the focus on achieving 'normal birth', and the contribution this has made to avoidable harm and death.

- There has been a lack of professional leadership in addressing these concerns. While professional bodies (including the Royal Colleges) have made statements in response to reviews that have recognised the negative impact that these professional beliefs have had, it is not clear what proactive steps are being taken to address them.

- Promotion of "normal birth" continues to feature within parts of midwifery education. The NMC standards for proficiency for midwives are referred to as meeting the ICM 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.

Reviewing previous recommendations

- The Joint Policy Unit has previously reviewed recommendations relevant to saving babies' lives and tackling inequalities from 30 reports and reviews into the safety of maternity and neonatal services to identify key recurring themes. These are summarised in the table below:

Theme	Description
Staffing levels and training	Staffing levels need to be sufficient to ensure safe care. Workforce plans must be owned by the board with clear mitigation/escalation policies in place when staffing is unsafe. Staff must be suitably qualified with senior staff present on labour wards. All staff must have access to the training that is required for them to carry their roles safely and effectively. To support teamworking, training should be multi-professional and support working together with a shared purpose. It should also include a focus on situational awareness and human factors.
Culture of safety within organisations	Staff must be able to escalate concerns about clinical care whenever necessary, with clear protocols in place to support this. Staff must be able to report safety concerns without fear of reprisal or repercussions. Organisations must review their approach to reputation management and ensure an open learning culture from board to ward level.
Organisational leadership	Safe care must be a shared goal throughout organisations. Boards must take effective ownership of the safety of maternity services with strong oversight of quality and performance of services. Clear arrangements should be in place for sharing patient experience at board level.
Personalisation of care and choice	All women and birthing people should be able to make informed decisions about their care. This includes decisions about mode and place of birth – based on full, impartial information about the safety risks associated with all birth options.
Reducing inequities	Initiatives need to be focussed on improving care for those at increased risk of worse outcomes to reduce rates of miscarriage, stillbirth, neonatal death and preterm birth. This includes accurately recording ethnicity data and using it to respond to risk factors. It also involves working with women and birthing people from minoritized ethnic backgrounds, and other disadvantaged communities, to tailor care and improve outcomes.
Data collection and use	Data collection must help identify variation in outcomes between maternity units, and among different patient groups (for example among women from Black and minority ethnic groups). Steps must be taken to understand the causes of variation and to inform improvements. Better data collection needs to be supported by improving access to digital maternity records.
Learning from reviews and investigations	There should be a standardised, consistent approach to reviews and investigations of serious incidents, with adequate resourcing and families involved in a compassionate manner. Systems must be in place to support the sharing of learning locally, regionally and nationally – with clear actions implemented to address concerns raised.
Engaging with service users	Services must actively engage with, learn from and listen to the needs of women and birthing people. This includes ensuring they are involved in reviews and investigations and consulted on the design and delivery of services.
Delivering care in line with nationally-agreed standards	Reports have consistently highlighted the need to provide timely and responsive care in line with national guidelines. Specific areas that have consistently been identified as requiring improvements are highlighted in Appendix A.

- From our work in this area, it is clear that there is a lack of ownership and accountability for implementing these recommendations. This is explored further in the section below on barriers.

Identifying opportunities and barriers to potential improvements

Lack of accountability for progress

- We have previously highlighted how lack of accountability is a significant barrier to progress. This includes accountability of the NHS nationally, arms-length bodies, as well as professional and representative bodies.

- With multiple recommendations from different reports which don't always neatly fit together, there is currently no consensus on how recommendations should be implemented, or the resources needed to implement them effectively. To move forward we need much stronger national leadership to prioritise and sequence these recommendations, while also determining who is responsible for delivering them and properly overseeing its progress.

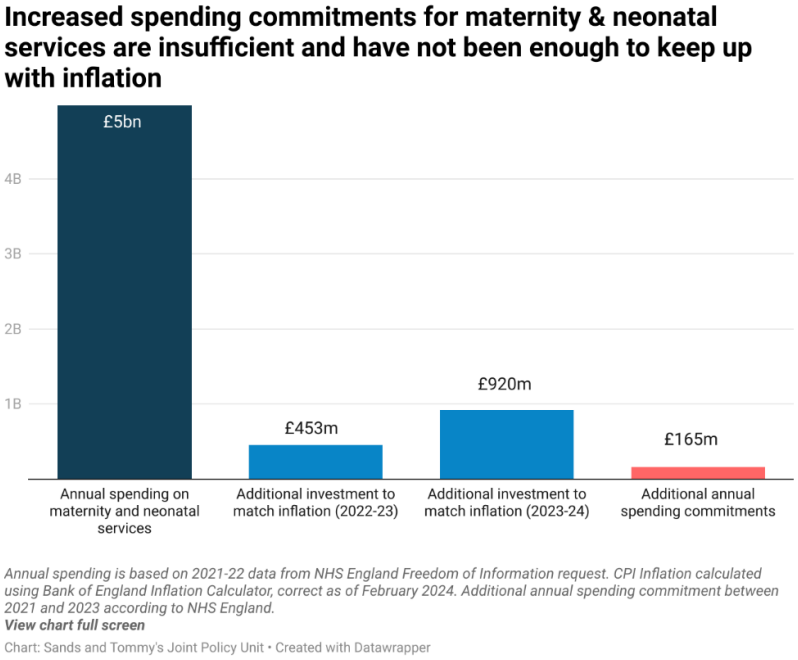
Lack of effective evaluation

- To make progress we need a commitment to evidence-based policy and rigorous evaluation of what works. The initiatives 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.

- A renewed policy approach to improving the safety of maternity and neonatal services must ensure changes or initiatives intended to support improvement are rigorously evaluated.

Investigating revenue and capital investment

- Previous work from the Joint Policy Unit has looked at investment in maternity and neonatal services in England and found a disconnect between public statements on investment and actual data on funding. Many headline announcements have been insufficient to keep pace with inflation.



- Many respondents from our call for evidence highlighted the importance of sufficient funding to enable staff to deliver care in line with guidance, engage with service users and attend training.