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Quality and safety of maternity care (England)

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Contents

Summary

This research briefing sets out the current policies addressing the quality and safety of health services in England and discusses recent concerns over maternity safety and disparities in maternal health between ethnic groups.

Health services are a devolved policy responsibility. This briefing refers to the position in England.

Concerns about the quality and safety of maternity services

The quality and safety of maternity services has been a focus of national policy in recent years following several independent investigations into maternity and neonatal services at specific NHS Trusts, including The Report of the Morecambe Bay Investigation (2015; PDF), the Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (March 2022) and the report into Maternity and neonatal services in East Kent (October 2022).

An independent review into the quality and safety of care at Nottingham University Hospitals maternity services is currently underway; a separate police investigation is being launched and will take place alongside the independent review.

Concerns about safety within maternity services have also been raised in Care Quality Commission (CQC) ratings; in 2021, 38% of maternity services were rated as requiring improvement for safety.

Independent investigations also raised concerns about staffing levels and their impact on patient safety. The Royal College of Midwives notes the midwifery workforce has not kept up with higher demands due to an increasing proportion of pregnancies and births for women who have medical and social needs combined with Government policies to provide women with more personalised care and greater continuity of care.

Policies to improve quality and safety

The most recent policy for maternity care is set out in NHS England's three year delivery plan for maternity and neonatal services, published in March 2023. The plan is centred around four key themes:

- Listening to women and families with compassion
- Supporting our workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures.

This three-year plan builds on maternity safety measures in the NHS Long Term Plan (January 2019) and on the work of the Maternity Transformation Programme.

The National Maternity Safety Ambition, launched in 2015, aims to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025. The latest statistics show that neonatal and maternal death rates appear unlikely to halve by 2025. Although the stillbirth rate fell by more than 20% between 2010 and 2020, more recent figures for 2022 show that the rate has since increased and a 50% reduction by 2025 may not be met.

Response to concerns

In July 2023, the Government published its full response to an independent review into maternity failings at East Kent Hospitals NHS Trust.

At a national level, this committed the Minister for Mental Health and Women's Health Strategy to chair a newly created maternity and neonatal care national oversight group. This will bring together the stakeholders from the NHS and other organisations to look at maternity and neonatal improvement programmes and the implementation of recommendations.

Following concerns about failures by maternity services to investigate and learn from patient safety incidents, in 2018 the Healthcare Safety Investigation Branch became responsible for conducting independent maternity investigations for all cases of early neonatal deaths, term intrapartum stillbirths and cases of severe brain injury in babies and maternal deaths. Responsibility for maternity investigations transferred to CQC on 1 October 2023.

To address staffing concerns, NHS England has provided recent funding aimed at expanding the workforce, including £127 million in March 2022 to boost the workforce and help improve the culture in maternity units.

Disparities in maternal health between ethnic groups

There has been notable press coverage of concerns about disparities in maternal health between ethnic groups, with Black women having

particularly poor outcomes. For example, the 2022 MBRRACE-UK report (PDF) has demonstrated that Black women were at almost four times greater risk of maternal mortality than White women.

The reasons for these disparities are not fully understood, but differences in the incidence of deprivation, co-morbidities and pre-existing conditions between ethnic groups and barriers to engagement with health services for some groups (PDF) are thought to contribute.

Other factors relate to the experience and treatment of Black and minority ethnic women within maternity services. Respondents to the Black Maternity Experiences Survey (2022) reported concerns about the standard of care they received during labour, and how their concerns were addressed by professionals.

There are concerns that Black and minority ethnic women's experience of maternity services may be negatively affected by implicit or explicit racism and negative perceptions of religious and cultural practices within maternity services.

Measures to address health disparities

The Government's Women's Health Strategy for England (2022) set out plans to address health disparities, including through the Maternity Disparities Taskforce, which was to explore disparities in maternity care and address poor outcomes among women from minority ethnic backgrounds and those living in deprived areas.

In June 2023, the Women and Equalities Committee published its report, Black maternal health, expressing concern about Black women's experience of maternity services and concern that "Government and NHS leadership have underestimated the extent to which racism plays a role".

Responding in June 2023 (PDF), the Government welcomed the Committee's report and said it remained committed to tackling maternal inequalities and improving equity for mothers and babies. The Government did not commit to producing a cross-Government target and strategy for eliminating maternal health disparities, as recommended by the Committee.

Another Committee recommendation was that a review be carried out into education and continuing professional development for maternity staff in relation to maternal disparities. The Government said that NHS England would carry out a scoping exercise to inform the review.

1 Maternity care policies

1.1 How are maternity services arranged?

NHS Trusts are the main providers of maternity services in the NHS. Integrated Care Boards (ICBs), introduced by the Health and Care Act 2022, commission most maternity services. Each ICB is a partner in an Integrated Care System (ICS).

ICSs are a partnership of organisations that plan and deliver joined up health and care services. The local maternity and neonatal system (LMNS) is the maternity and neonatal arm of the ICS. ICBs also commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision-making.

NHS England has responsibility for commissioning neonatal critical care services, under its specialised commissioning role. Currently, Neonatal Operational Delivery Networks are commissioned by NHS England's Specialised Commissioning team. However, NHS England's Roadmap for integrating specialised services (May 2022) sets out how ICSs will soon be given a bigger role in commissioning some specialised services, including neonatal services.

1.2 Government and NHS policies to improve care

This section describes recent Government and NHS policy initiatives to improve patient safety and quality of care in maternity services.

The annual CQC Maternity Survey contributes to monitoring progress against Government aims by asking women about their experiences of care provided before giving birth (antenatal care), during labour and delivery, and in the 6 to 8-week period following birth (postnatal care). The 2022 maternity survey showed that women's experiences of care had deteriorated in the last 5 years; fewer women feel they always got the help they needed during labour and birth and a significant number reported that they did not feel listened to when raising concerns.

Government response to Dr Kirkup's report into East Kent (July 2023)

On 21 July 2023, the Government published its full response to the independent review into maternity and neonatal services at East Kent Hospitals University NHS Trust. Dr Kirkup's Reading the signals report concluded that the trust failed to provide safe care and treatment which resulted in avoidable harm for mothers and babies, and made recommendations for the healthcare system.

The Government's response sets out actions to improve safety for mothers and their babies within the NHS to improve maternity and neonatal care standards. Whilst the report focuses on the situation in East Kent, the Government has said its recommendations will be implemented nationwide.

At a national level, this committed the Minister for Mental Health and Women's Health Strategy to chair a newly created maternity and neonatal care national oversight group. This will bring together key people from the NHS and other organisations, including the CQC and HSIB, to look across maternity and neonatal improvement programmes and the implementation of recommendations from this and other maternity reviews, to ensure a joined-up and effective approach.

Further actions include:

- a special data taskforce has been set up by NHS England to better monitor patient safety in maternity and neonatal care nationwide
- relevant bodies will work with DHSC to investigate how teamwork in maternity and neonatal care spaces can be improved
- relevant bodies will work with DHSC to investigate how doctors in training can be better trained to improve teamworking and their own personal development
- Trusts will have to ensure there is proper representation of maternity care on their boards
- The Government will continue to work with NHS England on its approach to poorly performing trusts and their leadership.[1]

NHS England: Three year delivery plan for maternity and neonatal services (March 2023)

In March 2023, NHS England published a three year delivery plan for maternity and neonatal services. The plan sets out a series of actions for trusts, Integrated Care Boards and NHS England to make maternity and

[1] Government acts to boost the quality of care for mothers and babies - GOV.UK (www.gov.uk)

neonatal care safer, more personalised, and more equitable for women, babies and families.

The plan is centred around four key themes:

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures.

Further detail on these areas is provided below.

Listening to woman and families with compassion

This theme identifies that listening and responding to all women and families is an essential part of safe and high-quality care, as emphasised in the recent Ockenden and Kirkup reports, the latter of which identified "repeated failures to listen to the families involved" in East Kent maternity and neonatal services.

The first objective under this theme is ensuring that all women are offered personalised care and support plans as part of their care. This should take account of their physical health, mental health, social complexities, and choices.

It sets out that women should be offered practical support and information, such as for smoking cessation, and equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed. The NHS will also invest to ensure the availability of bereavement services 7 days a week by the end of 2023/24 for women and families who experience loss.

The second objective is to improve equity for mothers and babies by addressing key health inequalities. This objective requires trusts to pay particular attention to health inequalities in providing services, for example choice of pain relief in labour where there are known inequalities, ensuring access to interpreter services and implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived areas.

Growing, retaining and supporting our workforce

NHS England's report recognises that the ambitions of the plan "can only be delivered by skilled teams with sufficient capacity and capability" and maternity and neonatal services do not currently have the number of

midwives, neonatal nurses, doctors, and other healthcare professionals they need.[2]

Key commitments in this area include:

- NHS services will ensure the right numbers of the right staff are available to provide the best care for women and babies through regular local workforce planning, including trusts meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.
- Implementing staff retention improvement action plans to identify and address local retention issues. During 2023/24, retention midwives will be funded in every maternity unit.
- Supporting the retention and recruitment of staff caring for babies in neonatal units by continuing to invest in education and workforce leads.
- Providing a core competency framework that will inform local mandatory training programmes to ensure that the skills relevant to staff's roles are kept up to date.[3]

Further information on safe staffing is available in section 2.4.

Developing and sustaining a culture of safety to benefit everyone.

This theme sets out actions to develop a positive safety culture; it focuses on cultural issues identified in the Kirkup report into East Kent services, including teamworking, professionalism, compassion, listening, and learning.

Key commitments in this area include:

- Throughout 2023, effectively implement the NHS-wide Patient Safety Incident Response Framework (PSIRF) approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.[4]

2 NHS England, Three year delivery plan for maternity and neonatal services, 30 March 2023
3 As above
4 As above

Meeting and improving standards and structures that underpin NHS national ambitions.

This theme acknowledges the need to support maternity and neonatal teams with clear standards and structures, including clinical best practice, the provision of high-quality data, and effective digital tools.

Key commitments include:

- Making care safer by consistently implementing best practice, including:
  - By 2024, an updated version of the updated Saving Babies Lives Care Bundle – a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
  - By 2025, the national maternity early warning score and updated newborn early warning trigger and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed.
- In 2023, NHS England's new taskforce will report on how data can be used as an early warning system to detect safety issues within maternity and neonatal services, enabling action to address any issues sooner.
- By 2024, the NHS will publish refreshed data and recording standards that allow us to collect more meaningful standardised data that can then be used to improve care.
- Supporting the roll out electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.[5]

The maternity hub on the FutureNHS platform has relevant material for each theme.

The Women's Health Strategy for England (August 2022)

The Women's Health Strategy 2022 (published August 2022) sets out Government actions to improve women's health across the life course, focusing on women-specific health services. It aims that within the next ten years, the Strategy will boost health outcomes for all women and girls and radically improve the way the health system listens to and engages with them. The Government have appointed the first Women's Health Ambassador for England, Professor Dame Lesley Regan, to champion women's voices and support delivery of the Women's Health Strategy.

[5] NHS England, Three year delivery plan for maternity and neonatal services, 30 March 2023

The strategy highlighted failures to put women at the heart of health services and identified a lack of listening to women as a key failure within health services, particularly within maternity services. Within the responses to the call for evidence, 84% of respondents identified this as a failure.

The Strategy focuses on key areas of health where the call for evidence highlighted particular issues or opportunities, including fertility, pregnancy, pregnancy loss and postnatal care. Under this theme, actions include the expansion personalised maternity care, including the roll-out of midwifery continuity of carer (for which the target dates have subsequently been scrapped) prioritising those most likely to experience health disparities and roll out of maternal medicine networks to reduce rates of maternal mortality.

The strategy also details recent safety initiatives for mothers and babies, including the Avoiding Brain Injury in Childbirth Collaboration, a national improvement programme which is due to be implemented across maternity services in England.

The Government has also commissioned research through the NIHR into maternal and neonatal health, focusing on the safety of maternity services for women and babies, including a £5 million policy research unit on maternal and neonatal health and care research based at the University of Oxford. This is researching high-priority areas around 5 themes of:

- preconception health and prevention
- pregnancy loss, and perinatal morbidity and mortality
- women's experiences of care and its impact on their health
- neonatal care
- health systems

The Strategy also details the £302 million investment in family hubs and the Start for Life programme. The package includes £82 million to create a network of family hubs in 75 upper-tier local authorities across England, £100 million for bespoke parent-infant relationship and perinatal mental health support, and £50 million to establish breastfeeding support services.

One year on from the launch of the Women's Health Strategy, the Government announced further measures including increased support for bereaved parents who have experienced pregnancy loss and a £25 million investment so every area in England can create a women's health hub, with each ICB given £595,000 to meet local women's health and wellbeing needs.[6]

[6] Boost for women and girls as Women's Health Strategy turns one - GOV.UK (www.gov.uk)

NHS Long Term Plan (January 2019)

The NHS Long Term Plan (January 2019) set out how maternity services will accelerate action to achieve the National Maternity Safety Ambition to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025.

The Long Term Plan set out targets including:

- Rolling out the Saving Babies Lives Care Bundle to every maternity unit by 2019
- By March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally.
- By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices.
- Improving access to and the quality of perinatal mental health care
- All maternity services that do not deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, will begin the accreditation process in 2019/20

The NHS Long Term Plan also committed to improving how the NHS learns lessons when things go wrong. It noted the role of the Healthcare Safety Investigation Branch (HSIB) in reviewing all term stillbirths, early neonatal deaths and cases of severe brain injury in babies, as well as all maternal deaths. The Plan also stated that "by spring 2019" every trust in England with a maternity and neonatal service would be part of the National Maternal and Neonatal Health Safety Collaborative.

National Maternity Review and Better Births (2016)

In 2015, NHS England commissioned an independent National Maternity Review to assess current maternity care provision and consider how services should be developed to meet the changing needs of mothers and babies.

The report of this review, Better Births, was published in 2016 and found that whilst there had been significant improvements in maternity care over the last decade, geographical variations remained and there were opportunities to improve safety of care and reduce still births.

The report highlighted seven priorities to drive improvements for maternity care. These included that women should be able to have care focused on their personal needs and choices, that women should have a named midwife, who is known to them and based in the community, and that there should be improvements in the provision of perinatal and postnatal mental healthcare.

The Maternity Transformation Programme Board was tasked with leading the implementation of the Maternity Review, including work to reduce the rate of

stillbirths, neonatal and maternal deaths in England. As well as coordinating action at a national level, the programme supports local design and delivery of maternity services through Local Maternity Systems (LMSs).

NHS England's 2022/23 priorities and operational planning guidance has recently reinforced the NHS' commitment to delivering the vision of Better Births. LMSs are asked to continue to work with providers to implement local plans to deliver continuity of carer, offering every woman a personalised care and support plan, and providing a preterm birth clinic.

However, in September 2022 NHS England announced that there will no longer be a target date for services to deliver Midwifery Continuity of Carer and local services will instead be supported to develop local plans that work for them. NHS England noted that this model of care requires appropriate staffing levels to be implemented safely, but currently maternity services are "experiencing stress and strain" and the focus should instead be on ensuring that maternity services have the right workforce.[7]

Maternal mental health

Information on maternal and perinatal mental health is available in the Library briefing on Mental health policy in England (section 1.3), updated September 2023. This includes information on Government initiatives to expand maternal mental health services, psychological support for birth trauma and perinatal mental health services.

[7] NHS England, Midwifery Continuity of Carer, September 2022

2 Maternity safety

Failures in maternity safety have been identified in independent reports into individual Trusts.

The report of the investigation into maternity safety incidents between 2004 and 2013 at University Hospitals of Morecambe Bay NHS Foundation Trust, led by Dr Kirkup, uncovered "serious and shocking" failings in care. The review catalogued "a series of failures at almost every level–from the maternity unit to those responsible for regulating and monitoring the Trust"[8], These included failures in risk assessment and care planning "that resulted in inappropriate and unsafe care" and failures by staff to escalate clear concerns that posed a threat to safety.[9]

Since the Morecambe Bay investigation, major failures in maternity care and safety have also been uncovered at Shrewsbury and Telford Hospital NHS Trust (March 2022) and East Kent Hospitals University NHS Foundation Trust (October 2022).

The final report of the independent review into Shrewsbury and Telford Hospital NHS Trust (March 2022), led by Donna Ockenden, detailed immediate and essential actions (IEAs) for improving the safety of all maternity services across England, including multidisciplinary training programmes, an escalation policy where staffing falls below agreed minimum levels, and policies for staff to escalate concerns.

The Ockenden report also found that the Trust had "failed to investigate, failed to learn and failed to improve" following serious maternity incidents, and recognised a critical need for timely and independent reviews to ensure lessons are learned and changes implemented effectively.[10]

Similarly the Reading the signals report of the independent investigation into maternity and neonatal services in East Kent (October 2022), led by Dr Kirkup, found that services provided clinical care that was suboptimal and led to significant harm, whilst also failing to listen to the families involved. The report also identified "clearly a failure to learn in the aftermath of obvious safety incidents."[11]

In evidence given to the Health and Social Care Committee inquiry into the safety of maternity service in England (2021), the CQC's Chief Inspector of

8 Morecambe Bay Investigation Report, 2015
9 Morecambe Bay Investigation Report, 2015
10 Department of Health and Social Care, Final report of the Ockenden review (March 2022), i
11 Dr Bill Kirkup CBE, Reading the signals report of the independent investigation into maternity and neonatal services in East Kent (October 2022), page 3

hospitals noted that 38% of the current CQC current ratings for maternity services are that they require improvement for safety, noting that this "is a reflection of the cultural issues in maternity services nationally."[12]

NHS England launched the national Maternity Safety Support Programme in September 2017. Maternity services are formally entered onto the programme if they are rated requires improvement or inadequate in the well led and/or the safe domains by the CQC. A list of maternity services currently on the Programme is available on the NHS England website.

The Health and Social Care Committee's independent Expert Panel conducted analysis in July 2021 of the Government's progress in achieving its own maternity safety goals. The overall rating across all commitments was assessed as "Requires Improvement"; the Panel gave "inadequate" ratings for maternal deaths and personalised care commitments, "requires improvement" for safe staffing and continuity of care, and "good" ratings for progress on reducing neonatal deaths and stillbirths. The Committee noted that:

> We're pleased to see that the Government is on track to meet its ambition of halving stillbirths and neonatal deaths by 2025. However, the findings from our Expert Panel clearly highlights that there is some way to go in achieving safe and personalised care for all.[13]

2.1 National Maternity Safety Ambition

The National Maternity Safety Ambition, launched in November 2015, aims to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025, with an interim ambition of a 20% reduction in these rates by 2020.

The original ambition was to halve these rates by 2030 but it was brought forward in November 2017 following the provision of additional funding and support.

An additional ambition to reduce the pre-term birth rate from 8% to 6% was also introduced in 2017, in line with a new Government action plan, Safer Maternity Care: The National Maternity Safety Strategy.

In line with the National Maternity Safety Ambition, maternity services were tasked to develop initiatives that could be more widely adopted across the country as part of a national approach, such as appointing maternity safety champions to report at board level and improving staff training to enable midwives to identify risks and symptoms associated with perinatal mental illness. Trusts were provided with a share of over £4 million of Government

[12] Health and Social Care Select Committee, Safety of maternity services in England (parliament.uk), 6 July 2021, para 7

[13] As above, para 17

funding "to buy high-tech digital equipment and to provide training for staff already working to improve outcomes for mums and babies".[14]

Over £1 million was allocated to funding the rollout of training packages developed with the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. In addition, the Government announced that £500,000 would be allocated to developing a new system for staff to review and learn from every stillbirth and neonatal death.[15] (Information on maternity investigations is available in section 2.3 below).

In October 2016, the Department of Health published Safer Maternity Care: Next steps towards the national maternity ambition, which provided guidance for Trusts to drive improvements in maternity services. The plan is part of the 'Promoting good practice for safer care' workstream of the Maternity Transformation Programme, in line with the objectives set out in the National Maternity Review, Better Births.

The Government announced an £8 million Maternity Safety Training Fund to enable Trusts to use multi-disciplinary training to improve their maternity safety. The plan also included a new £250,000 Maternity Safety Innovation Fund which invited funding bids for pioneering proposals for new ways to drive improvements in maternity safety.

In 2016, NHS England published the Saving Babies' Lives Care Bundle, aimed at reducing perinatal mortality. The guidance is designed to tackle stillbirth and early neonatal death, by bringing together five elements of care:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour
5. Reducing preterm birth

The fifth element was added in 2019, in line with the Government's refreshed Maternity Safety Strategy - Safer Maternity Care: The National Maternity Safety Strategy Progress and Next Steps (2017) - which extended the national ambition to include reducing the national rate of pre-term births from 8% to 6%.

The 2017 Strategy also brought forward the target date for halving of neonatal deaths, maternal deaths, injuries and stillbirths from 2030—the original planned date—to 2025:

> Around 55,000 babies are born pre-term (i.e. 24 - 36 weeks gestation) each year. This represents a national pre-term birth rate of 7.9% in England and

[14] Department of Health, New ambition to halve rate of stillbirths and infant deaths, 13 November 2015
[15] Department of Health, New ambition to halve rate of stillbirths and infant deaths, 13 November 2015

> Wales. We need to focus efforts on reducing the pre-term birth rate if we are going to achieve the national Maternity Safety Ambition.
>
> To encourage this additional focus, the Department of Health is setting an additional ambition to reduce the national rate of pre-term births from 8% to 6% by 2025.
>
> We are currently on track to meet our ambition to reduce stillbirths, neonatal and maternal deaths by 20% by 2020. The range of additional funding and support should enable maternity and neonatal services to go farther and faster.
>
> We have, therefore, decided to re-set the national Maternity Safety Ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth to 2025.[16]

As noted above, the NHS Long Term Plan (January 2019) set out a range of measures related to the improvement of maternity and neonatal services. These included a commitment to accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

The NHS Long Term Plan also committed to improving how the NHS learns lessons when things go wrong. In particular, it noted the role of the Healthcare Safety Investigation Branch (HSIB) in reviewing all term stillbirths, early neonatal deaths and cases of severe brain injury in babies, as well as all maternal deaths. The Plan also stated that every Trust in England with a maternity and neonatal service would be part of the National Maternal and Neonatal Health Safety Collaborative.[17]

As described in section 1.2, NHS England's three year delivery plan for maternity and neonatal services (March 2023) sets out actions to improve patient safety. Key actions include:

- Throughout 2023, effectively implement the NHS-wide "PSIRF" [Patient Safety Incident Response Framework] approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and Trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.[18]

16 Department of Health, Safer Maternity Care: The National Maternity Safety Strategy Progress and Next Steps, November 2017, p9

17 NHS Long Term Plan (7 January 2019) paragraph 3.9 to 3.21

18 NHS England, Three year delivery plan for maternity and neonatal services, March 2023

The Government announced further funding for maternity safety measures in the Spring Budget 2024:

> The government and NHS England are investing £35 million over three years to improve maternity safety across England, with specialist training for staff, additional midwives and support to ensure maternity services act on women's experiences to improve care. This package will include:
>
> - £9 million over three years, to roll out the Avoiding Brain Injuries in Childbirth programme across maternity units in England to provide maternity services with the tools and training to reduce avoidable brain injuries in childbirth.
> - Further investment in training to ensure the NHS workforce has the skills needed to provide ever safer care. We will train an additional 6,000 midwives in neonatal resuscitation and nearly double the number of clinical staff who have received specialist training in obstetric medicine in England.
> - Increasing the number of midwives by funding 160 new posts over three years to support the growth of the maternity and neonatal workforce.
> - Funding to support the rollout of Maternity and Neonatal Voice Partnerships, to improve how women's experiences and views are listened to and acted on to improve care.[19]

2.2 Statistical update: National Maternity Safety Ambition targets

The Government's National Maternity Safety Ambition including targets, using a 2010 baseline, to halve the rate of:

a) stillbirths
b) neonatal deaths
c) maternal deaths
d) brain injuries in babies

by 2025, with a 20% reduction by 2020.

The table below shows progress up to 2020 against these targets. Neonatal and maternal death rates did not meet the 20% reduction by 2020 target and appear unlikely to halve by 2025.

In addition, although the still birth rate fell by more than 20% between 2010 and 2020 more recent figures for 2022 show that the rate has since increased to 4.0 per 1,000 live births. Hence, a 50% reduction by 2025 may not be met.

[19] HM Treasure, Spring Budget 2024, Box 2.B NHS productivity plan and funding

National Maternity Safety Ambition targets

	Baseline	2020	% change
Stillbirths per 1,000 live births	5.1	3.8	-25%
Neonatal deaths per 1,000 live births	2.9	2.7	-7%
Maternal deaths per 100,000 maternities[(a)]	10.6	10.9	+3%

Notes: a) Latest estimate of maternal mortality is for 2018-20

Sources: ONS Births in England and Wales 2022, Childhood, infant and perinatal mortality in England and Wales 2021 and MBRRACE-UK Confidential Enquiry into Maternal Deaths 2018-20

In relation to the target to reduce the rate of intrapartum brain injuries, comparable baseline data is only available from 2012 onwards.

The latest estimates available are for 2019 and indicate that the most recent rate (4.16 deaths per 1,000 live births) is broadly similar to the 2012 level (4.16 per 1,000 live births)[20].

2.3 Learning from patient safety incidents: maternity investigations

Maternity and Newborn Safety Investigations

The Morecambe Bay Investigation report (published 2015) found that the response by the Trust to maternity incidents was "grossly deficient" with repeated failure to investigate properly and learn lessons.[21] Similarly, the Ockenden report on Shrewsbury and Telford Hospital NHS Trust (March 2022) echoed those concerns, describing investigations as "cursory", noting that they did not identify underlying systemic failings and some significant cases of concern were not investigated at all.[22] The report into East Kent maternity and neonatal services (October 2022) found that the Trust did not acknowledge errors openly and try to learn from them, where "safety investigations were often conducted narrowly and defensively, if at all, and not in a way designed to achieve learning."[23]

[20] Imperial College, Brain injury occurring during or soon after birth: 2019

[21] Dr Bill Kirkup CBE, The Report of the Morecambe Bay Investigation, March 2015

[22] Final report, Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, 30 March 2022

[23] Dr Bill Kirkup, Maternity and neonatal services in East Kent: 'Reading the signals' report, October 2022

In 2016, the National Maternity Review, Better Births, highlighted that there was no standard approach across Trusts for investigations:

> Some involve external, independent input; others do not. Some involve families in a compassionate and caring way; others do not. Some approach the exercise with a genuine desire to learn and improve quickly; others do not. Some can demonstrate genuine action plans leading to changes in practice; others cannot. This cannot be acceptable, when the implications for families of such incidents are so great.[24]

The report recommended that there should be greater consistency in the standard of local investigations of perinatal mortality, neonatal mortality, maternal death and serious morbidity. It stated that the new Health Safety Investigation Branch (HSIB) should set a common, national standard for high quality serious incident investigations.

The Secretary of State for Health and Social Care announced in November 2017 that the HSIB would investigate:

- all cases of early neonatal deaths, term intrapartum stillbirths and cases of severe brain injury in babies (Each Baby Counts cases) in England
- all cases of maternal deaths in England (where women die while pregnant or within 42 days of the end of their pregnancy)

Directions were tabled in Parliament to provide HSIB with a remit to conduct the maternity investigations programme and came into effect on 30 April 2018. Full national coverage was achieved in April 2019.

The core aims of the maternity investigations programme are to:

- Use a standardised approach to maternity investigations without attributing blame or liability.
- Work with families to make sure we understand from their perspective what has happened when an incident has occurred.
- Work with NHS staff and support local Trust teams to improve maternity safety investigations.
- Bring together the findings of our reports to identify themes and influence change across the national maternity healthcare system.[25]

HSIB published annual reports of the maternity investigation programme detailing common themes from maternity investigations and safety recommendations given to Trusts.

In its report on the safety of maternity services in England (June 2021), the Health and Social Care Committee found concerns around the timeliness of

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24 NHS England, National Maternity Review, Better Births, para 4.60

25 HSIB, Maternity Investigations, last accessed 30 August 2023

HSIB investigations. It also found there was still work to be done to improve the relationship between HSIB and Trusts to ensure there is local ownership of recommendations made and that investigations maximise learning at the local level.[26]

Responsibility for the maternity investigation programme transferred from HSIB to the Maternity and Newborn Safety Investigations Special Health Authority hosted by the CQC on 1 October 2023. This was announced via Ministerial Statement, in which the Department of Health and Social Care said that that the most "appropriate and streamlined mechanism" for delivering the investigations is for the function to be hosted within the CQC.[27]

The Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions 2023, published 1 October 2023, provide the CQC with the remit to carry out the programme.

Perinatal Mortality Review Tool

Additionally, the Perinatal Mortality Review Tool (PMRT), introduced in early 2018, supports standardised perinatal mortality reviews across NHS maternity and neonatal units in the UK. Reviews focus on the circumstances and care leading up to and surrounding baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths and neonatal deaths.

The fourth annual report, Learning from Standardised Reviews When Babies Die (September 2022), presents an analysis of data from the 4,199 reviews completed between March 2021 and February 2022. It combines findings from individual reviews and generate national-level recommendations for improvements in care.

Coronial investigation of stillbirth

At present, coroners do not have jurisdiction to conduct an investigation concerning a foetus or a stillborn child, as where there has not been an independent life, there has not legally been a death. [28] The definition of stillbirth is based on there not having been an independent life.

Where there is doubt about whether a child was born alive or stillborn, the coroner can make preliminary enquiries to try to establish the position or can start an investigation.[29]

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26 Health and Social Care Committee, The safety of maternity services in England, 29 June 2021, para 71

27 Written Statement, Maternity Investigation Programme: Transition Update, 30 March 2023

28 Courts and Tribunals Judiciary, Chief Coroner's Guidance No.45 Stillbirth, and Live Birth Following Termination of Pregnancy, 3 February 2023

29 As above

In March 2019, the Ministry of Justice (MoJ) and DHSC carried out a consultation seeking views on proposals for introducing coronial investigations of stillbirth cases in England and Wales.

The objectives of the consultation proposals were to:

- bring greater independence to the way stillbirths are investigated
- ensure transparency and enhance the involvement of bereaved parents in stillbirth investigation processes, including in the development of recommendations aimed at improving maternity care
- effectively disseminate learning from investigations across the health system to help prevent future avoidable stillbirths

A summary of consultation responses was published in December 2023. The Government noted that there were mixed responses, for example with concerns raised about the potential impacts on bereaved families, and the potential for duplication between other types of mandatory investigations:

> The potential for duplication (and interaction issues) between investigations by the coroner, the Healthcare Safety Investigation Branch's maternity investigation programme (which is now the Maternity and Neonatal Safety Investigations programme), and the relevant trust or health board, which could have a knock-on impact for clinician behaviours or culture and could lead to confusion where different investigations make conflicting findings. It was noted that the investigatory processes introduced in 2018 would achieve the same policy objectives as coronial investigations.[30]

The Government gave a Written Ministerial Statement on the Coronial Investigations of Term Stillbirths: Summary of Responses to the Consultation on 7 December 2023. A further statement will be issued in due course, which sets out whether, and if so, how the Government intend to take action.

2.4 Safe staffing

Health and care providers have a legal duty to deploy enough suitably qualified staff to meet the needs of those using the service. There is no set formula or ratio for deciding safe, or minimum staffing, although there are tools and guidance available. The National Institute for Health and Care Excellence (NICE) have produced specific guidelines on Safe midwifery staffing for maternity settings (2015).

Birthrate Plus provides a framework to calculate safe midwifery staffing levels. Birthrate Plus recommends a ratio of 1 midwife for every 24 women, however the assessment of midwifery staffing requirements for services will

[30] Ministry of Justice, Department for Health and Social Care, Coronial investigations of stillbirths: factual summary of consultation responses, 7 December 2023

vary depending on factors including local caseloads, levels of complexity and acuity, models of care, and skill-mix.[31]

The Royal College of Midwives' (RCM) position statement on safer staffing (March 2022) notes that the combination of increasing proportion of pregnancies and births for women who have a medical and social needs alongside Government policies to provide women with more personalised care and greater continuity of carer have resulted in increased demands on maternity staff. The RCM notes that midwifery staff numbers have not kept pace with these changes:

> Existing staffing shortages – estimated by the RCM and Government ministers alike to be in the region of 2,000 full-time equivalent midwives in England – are having a significant impact on the workload and pressures experienced by midwives and MSWs [Maternity Supports Workers].[32]

Concerns about staffing levels have been raised in recent independent reviews. Suboptimal staffing levels were identified in the Morecambe Bay report and the Dr Kirkup report into maternity and neonatal services in East Kent also highlighted concerns about low staffing levels and the impact on patient safety.

The Health and Social Care Committee's Expert Panel assessed the Government's commitment on safe staffing in maternity services, that "NHS providers are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm". The Expert Panel rated progress overall towards achieving this ambition as 'requires improvement', stating:

> There is a consistent message in the range of sources we evaluated that staffing across the whole area of maternity services requires improvement. While there have been recent improvements in the number of midwifery staff, persistent gaps in all maternity professions remain. Current recruitment initiatives do not consider the serious problem of attrition in a demoralised and overstretched workforce and do not adequately value professional experience and wellbeing. Staffing deficits undermine the ability of Trusts to achieve improvements in all areas.[33]

The Government and NHS England are taking forward measures to expand the maternity workforce, as outlined below.

In March 2022, NHS England announced £127 million for maternity services to boost the workforce and help improve the culture in maternity units. NHS England provides the following breakdown in funding:

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31 The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, 30 June 2021, page 140

32 Royal College of Midwives, Position Statement: Safer staffing, March 2022

33 The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, 30 June 2021, page 6

> More than £50 million will be provided to Trusts across the country over the next two years to boost staffing numbers in maternity and neonatal services.
>
> Around £34 million will also be invested in local maternity systems, in culture and leadership development programmes and in supporting staff retention roles.
>
> In addition, around £45 million of capital funding will be available to hospitals over the next three years to increase the number neonatal cots across England, so that babies will receive the best quality care, in the most appropriate clinical setting.[34]

The new funding also builds upon the £95 million package of support for maternity services in England announced in 2021 to boost maternity workforce numbers with 1,300 new roles- 1200 midwives and 100 obstetricians - and the implementation of the three overarching themes identified in the Ockenden Report: workforce numbers, training and development programmes, and strengthening board assurance and surveillance to identify issues earlier.[35]

The DHSC has commissioned the RCOG, to develop a new obstetric workforce planning tool to calculate the number of obstetricians required locally and nationally to provide a safe, personalised maternity service.[36]

As noted above, NHS England's three year delivery plan for maternity and neonatal services (March 2023) sets out actions to expand the maternity workforce. Key actions include:

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, Trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and Trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.[37]

In June 2023, NHS England published the NHS Long Term Workforce Plan, as commissioned by the Government. Actions in the plan are backed by £2.4 billion in Government funding up to 2028/29. The Plan sets out a need to grow midwifery education and training, in line with the conclusions of the Ockenden review:

> Although birth rates are projected to fall for the remainder of this decade (before stabilising and then rising in the 2030s), the complexity of births is

34 NHS England, NHS announces £127 million maternity boost for patients and families, 24 March 2022
35 The Government's response to the Health and Social Care Committee report: safety of maternity services in England, October 2021
36 The Government's response to the Health and Social Care Committee's Expert Panel Evaluation, September 2021, page 18
37 NHS England, Three year delivery plan for maternity and neonatal services, March 2023

> rising. We know we currently have a shortfall of midwives and leaver rates are high. The assessment of the workforce required has been adjusted to reflect the staffing levels needed to deliver safe maternity services, and we envisage that trusts will meet establishment levels set by midwifery staffing tools and achieve fill rates by 2027/28. Recent investment in midwifery of 650 training places in 2019 and 1,000 in each of the following three years means we expect to see solid growth in midwives of 1.8–1.9% per year over the course of the Plan. These increases are being measured against the 2018/19 baseline of 2,715 starters. And in early 2022, a funding offer was agreed to support 300 places for adult nurses on the shortened midwifery programme until 2024. We anticipate upwards of 4,270 starters on midwifery programmes are likely in 2023/24, a 13% increase compared to 2021/22 levels. We will train more midwives through traditional, shortened and degree-level apprenticeship routes.[38]

Further detail is available in the Library briefing on The NHS Workforce in England, July 2023.

2.5 Birth trauma

In January 2024, the All-Party Parliamentary Group (APPG) on Birth Trauma established the first national inquiry in the UK Parliament to investigate the reasons for birth trauma and to develop policy recommendations to reduce the rate of birth trauma.

The inquiry received more than 1,300 submissions from people who had experienced traumatic birth, as well as nearly 100 submissions from maternity professionals:

> The stories told by parents were harrowing. They included accounts of stillbirth, premature birth, babies born with cerebral palsy caused by oxygen deprivation, and life-changing injuries to women as the result of severe tearing. In many of these cases, the trauma was caused by mistakes and failures made before and during labour. Frequently, these errors were covered up by hospitals who frustrated parents' efforts to find answers.
>
> There were also many stories of care that lacked compassion, including women not being listened to when they felt something was wrong, being mocked or shouted at and being denied basic needs such as pain relief. Women frequently felt they were subjected to interventions they had not consented to, and many felt they had not been given enough information to make decisions during birth. The poor quality of postnatal care was an almost-universal theme. Women shared stories of being left in blood-stained sheets, or of ringing the bell for help but no one coming.[39]

Their report, Listen to Mums: Ending the Postcode Lottery on Perinatal Care, was published in May 2024. It made recommendations that aim to address poor maternity care and work towards a maternity system that is woman-centred. The APPG calls on the UK Government to publish a National

38 NHS England, NHS Long Term Workforce Plan June 2023, pp 44-45

39 APPG on Birth Trauma, Listen to Mums: Ending the Postcode Lottery on Perinatal Care, 13 May 2024

Maternity Improvement Strategy, led by a new Maternity Commissioner who will report to the Prime Minister.

The report includes recommendations on safe staffing in maternity services, improving maternal mental health services, offering a separate 6-week check post-delivery with a GP for all mothers focusing on physical and mental health, and overseeing the national rollout of standardised post birth services, such as Birth Reflections, to enable all mothers to speak about experiences in childbirth.

The Health and Social Care Secretary, Victoria Atkins, gave a speech at the launch of the report and spoke of the "unacceptable variation across the country in the service that women receive." She highlighted the government's focus on birth trauma, including making birth trauma one of the top priorities for the second year of the Women's Health Strategy, rolling out new maternal mental health services for new mothers, improving perinatal pelvic health services and examining fathers' mental health and trauma.

The Secretary of State also announced that the National Institute for Health and Care Research (NIHR) will commission new research into the economic impact of birth trauma, including how this affects women returning to work.

Further detail on psychological support for birth trauma is available in the Library briefing on Mental health policy and services in England (October 2023).

3 Disparities in maternal health between ethnic groups

3.1 Background

There has been notable press coverage of concerns about ethnic disparities in maternal health, particularly among Black women.[40]

Some of the concerns are centred on disparities in health outcomes. For example, the 2022 MBRRACE-UK report (PDF) demonstrated that Black women were at almost four times greater risk of maternal mortality than White women (discussed further in section 3.2). [41] [42]

Other concerns have focused on the experience and treatment of Black and minority ethnic women within maternity services.

A May 2022 report published by Five X More,[43] The Black Maternity Experiences Survey, set out the experiences reported by 1,340 Black and Black mixed women in maternity care services. [44] Survey responses were submitted between April and June 2021.

Respondents reported facing challenges with healthcare professionals during their maternity care (54%), feeling the standard of care they received during childbirth was poor or very poor (42%), and feeling dissatisfied with how their concerns during labour were addressed by professionals (36%).

Some women said that their pain relief options were not explained to them (43%), and those who did not receive their choice of pain relief (52%) said

40 See for example, BBC News, Why are black mothers at more risk of dying?, 12 April 2019; Sky News, Black women five times more likely to die in childbirth – but NHS has 'no target' to end it, 25 November 2020; BBC News, Black women four times more likely to die in childbirth, 11 November 2021

41 MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) provides surveillance of all maternal deaths in the UK. MBRRACE-UK is a collaboration appointed by the Healthcare Quality Improvement Partnership. It delivers the Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP), which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. It also carries out confidential enquiries into maternal deaths during and up to one year after the end of the pregnancy.

42 MMBRACE-UK, Confidential Enquiry into Maternal Deaths 2018-20, 2022

43 Five X More is a grassroots organisation committed to changing Black women and birthing people's maternal health outcomes in the UK.

44 Five X More, The Black Maternity Experiences Report: A nationwide study of Black women's experiences of maternity services in the United Kingdom, May 2022

there was no explanation as to why it was not given to them. Some women reported feeling that their safety had been put at risk by professionals during labour or the recovery period (42%), although Black mixed women were 6% more likely to report their safety being put at risk than Black women.

As well as Five X More, other campaign groups have been working to highlight ethnic disparities in maternal health, including The Motherhood Group, Birthrights and the Muslim's Women's Network.

3.2 Maternal deaths by ethnic groups

The table below shows data from the latest 2022 MBRRACE-UK report on the Confidential Enquiry into Maternal Deaths 2018-20 highlighting the number of maternities and associated deaths by ethnicity.

The highest maternal death rate was observed among women from Black backgrounds, 34.0 deaths per 100,000 maternities. The risk of maternal death among Black women was almost four times as high as for White women.

Maternal deaths by ethnicity
England 2018-2020

Ethnic group	Total maternities	Deaths	Death rate per 100,000 maternities	Relative Risk: BAME compared with White ethnicity		
				Relative Risk ratio	Lower CI	Upper CI
White	1,448,043	128	9.2	1.0		
Asian	187,408	30	16.1	1.8	1.1	2.6
Black	79,098	26	34.0	3.7	2.3	5.7
Chinese/other	74,743	6	8.2	0.9	0.3	2.0
Mixed race	32,436	4	12.2	1.3	0.4	3.5

Source: MBRRACE-UK Confidential Enquiry into Maternal Deaths 2018-20, Table 2.10

The 95% confidence intervals (CIs) shown in the table above suggest that women from Asian and Black backgrounds have a statistically significant elevated risk of maternal death compared with women from White backgrounds, because the lower CIs for both groups are higher than 1.0.

The MBRRACE data is pooled over a three-year period because the small number of maternal deaths means that the estimated rates and ratios can be associated with a large degree of uncertainty.

The uncertainty of a ratio can be estimated by calculating a confidence interval (CI) around the estimate to give an indication of the range within which the "true" ratio is likely to arise. The confidence intervals are important in interpreting differences.

A confidence interval expresses the degree of uncertainty associated with a statistic and gives an indication that that actual "true" value may lie somewhere between the lower and upper confidence interval.

You can use the overlap in confidence intervals as a quick way to check for statistical significance. For relative risk, the difference is considered statistically significant if the CIs do not overlap 1.0.

Causes of ethnic disparities in maternal health

While the reasons for ethnic disparities in maternal health are not fully understood, several factors are thought to contribute, including:

- The incidence of pre-existing conditions and co-morbidities.[45]
- Socioeconomic factors including deprivation.[46]
- Underrepresentation of Black and minority ethnic women in maternal health research.[47]
- The aggregation of ethnic groups during data collection, making it difficult to identify trends among specific ethnic groups.[48]
- Incomplete or inadequate ethnicity data.[49]
- The provision of maternity care that is not culturally sensitive,[50] and that sometimes perpetuates racial or ethnic stereotypes about Black and minority ethnic women. [51]
- The presence and impact of implicit or explicit racism in women's access to treatment and the provision of care.[52]

45 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

46 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

47 Five X More, The Black maternity experiences survey, May 2022

48 Five X More, The Black maternity experiences survey, May 2022

49 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

50 British Journal of Midwifery, Ethnic health inequalities in the UK's maternity services: a systematic literature review, Vol 29, Issue 2, 2 February 2021

51 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

52 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

- The impact of cultural and religious practices on a) the way that maternity staff perceive and treat women in maternity services, and b) the relationship between staff and women accessing maternity services.[53]
- The impact of additional social needs, such as referrals to housing or financial services, on the way that maternity staff relate with women accessing maternity services.[54]
- Barriers to accessing maternity appointments, such as the availability of childcare, transport and translation services.[55]
- The impact of immigration status on women's presentation to and engagement with maternity services.[56]

Although not a cause of disparities, a 2022 report published by Sands and Tommy's Policy Unit noted that:

> Many qualitative studies on ethnic inequalities in maternity and neonatal care focus on previous experience and rarely ask about solutions, which women report finding disempowering.[57]

3.3 Government policy

The Women's Health Strategy for England, August 2022

The Government published its Women's Health Strategy for England in August 2022.[58] The Government noted that some respondents to the call for evidence (published ahead of the Strategy)[59] reported that ethnicity affected their experience of health and services. It also acknowledged disparities in maternal deaths, with Black and Asian women being more likely to die during pregnancy, childbirth and in the year following childbirth, than White women.

The Government set out plans to address health disparities, including through the Maternity Disparities Taskforce (see below), with a focus on women living in the most deprived areas and women from minority ethnic groups.

The Strategy set out a general ambition that underrepresented groups, including minority ethnic groups, be better represented in research and

53 British Journal of Midwifery, Ethnic health inequalities in the UK's maternity services: a systematic literature review, Vol 29, Issue 2, 2 February 2021
54 British Journal of Midwifery, Ethnic health inequalities in the UK's maternity services: a systematic literature review, Vol 29, Issue 2, 2 February 2021
55 Sands & Tommy's Policy Unit, Saving Babies' Lives 2023: A report on progress (PDF), May 2023
56 British Journal of Midwifery, Ethnic health inequalities in the UK's maternity services: a systematic literature review, Vol 29, Issue 2, 2 February 2021
57 Sands & Tommy's Policy Unit, Saving Babies' Lives 2023: A report on progress (PDF), May 2023
58 DHSC, Women's Health Strategy for England, 30 August 2022
59 DHSC, Women's Health Strategy: Call for evidence, published 8 March 2021

studies, and that these routinely collect data on demographics including ethnicity.

Addressing disparities in neonatal and maternal mortality, the Government referred to £6.8 million of funding, allocated to local maternity systems in 2021/22, to co-produce and implement equity and equality action plans. The funding was introduced as part of NHS England's guidance, Equity and Equality: Guidance for Local Maternity Systems, in September 2021 and was intended to support the implementation of continuity of carer for Black and minority ethnic groups and those living in the most deprived areas. The continuity of carer model is focused on delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy.

The Government has said that each Local Maternity and Neonatal System has produced an Equity and Equality Action Plan.[60]

The Maternity Inequalities Oversight Forum and the Maternity Disparities Taskforce

In September 2020, Nadine Dorries, then Minister for Patient Safety, Suicide and Mental Health, launched the Maternity Inequalities Oversight Forum. It aimed to "bring together experts to consider and address the inequalities of women and babies from different ethnic backgrounds and socioeconomic groups".[61]

The Government's most recent comment on the Forum, made in September 2021, notes that the Forum met in October 2020 and April 2021 and had not made any specific recommendations to the Department for Health and Social Care (DHSC).[62] The Government also said it was unable to provide the Forum's membership "as it relates to the formulation of Government policy".[63]

The Women's and Equalities Committee suggested in 2023 that the Forum has since disbanded.[64]

In February 2022, the DHSC announced that it had established a new Maternity Disparities Taskforce to "explore reasons for disparities in maternity care and address poor outcomes for women from ethnic minority communities and those living in deprived areas".[65] The Government also said the Taskforce will "bring together experts from across the health system,

60 PQ 191945, 10 July 2023
61 HC Deb, Women's Health Strategy, Vol 690, 8 March 2021
62 PQ 52485, 29 September 2021
63 PQ 52485, 29 September 2021
64 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023
65 DHSC and Maria Caulfield MP, New taskforce to level-up maternity care and tackle disparities, published 23 February 2022

Government departments and the voluntary sector to co-ordinate focus and deliver evidence-based interventions to address maternal disparities".[66]

As part of its 2023 inquiry on Black maternal health (see section 3.4), the Women and Equalities Committee recommended that the Government publish measures for gauging the success of the Taskforce, and that the Taskforce update the Committee on a six-monthly basis as to the progress it has made in addressing maternal health disparities.[67]

The Government said it was happy to update the Committee on a six-monthly basis. [68] However, it said it would not publish measures for gauging the success of the Taskforce, instead stating that there was "clear value" in "maintaining high level ambitions as opposed to specific deliverables".[69]

Wider work on health inequalities

NHS England has introduced the CORE20PLUS5 framework for adults, which focuses on reducing healthcare inequalities at a national and system level.[70]

The 'Core20' element of the programme focuses on the most deprived 20% of the national population.

The 'PLUS' element of the programme consists of population groups to be identified at a local level, and NHS England has set an expectation that minority ethnic communities would be included.

The '5' element of the programme concerns five focus clinical areas, one of which is maternity and ensuring continuity of care for women from Black and minority ethnic communities and the most deprived groups. NHS England is delivering a programme in which seven Integrated Care Systems have received funding and are serving as Accelerator Sites.[71]

The Government published its policy paper, Major conditions strategy: case for change and our strategic framework, in August 2023.[72] The paper notes that the Government's forthcoming Major Conditions Strategy will be published over 2023 and into 2024. The Government said that the forthcoming

66 PQ 191945 , 10 July 2023

67 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

68 House of Commons Women and Equalities Committee, Black maternal health: Government Response to the Committee's Third Report, HC 1611, (PDF) 30 June 2023

69 House of Commons Women and Equalities Committee, Black maternal health: Government Response to the Committee's Third Report, HC 1611, (PDF) 30 June 2023

70 NHS England, Core20Plus5 (adults) – an approach to reducing healthcare inequalities, accessed 19 September 2023

71 NHS England, Core20Plus5 (adults) – an approach to reducing healthcare inequalities, accessed 19 September 2023

72 DHSC, Major conditions strategy: case for change and our strategic framework, updated 21 August 2023

Strategy will include consideration of disparities in health outcomes, including "ethnicity, deprivation and inclusion health".[73]

3.4 The Women and Equalities Committee inquiry into Black maternal health (April 2023)

In early 2023, the Women and Equalities Committee held a one-off inquiry into Black maternal health, taking evidence from James Morris, the then Minister for Patient Safety and Primary Care, NHS leaders and campaign groups.

The Committee published its report, Black maternal health, in June 2023.[74] Concluding, the Committee described the causes of the disparity in maternal deaths as "multiple, complex and still not fully understood". The Committee said "too many Black women have experienced treatment that falls short of acceptable standards" and expressed concern that "Government and NHS leadership have underestimated the extent to which racism plays a role".

Its recommendations included that:

> There should be a cross-Government target and strategy, led by the Department of Health and Social Care, for eliminating maternal health disparities. The Maternity Disparities Taskforce should be charged with consulting on this strategy within its membership and more widely, and for proposing and developing metrics by which this target can be achieved and measured.[75]

The Committee also made a recommendation concerning the education and continuing professional development of maternity staff:

> Health Education England must lead a co-ordinated review involving the Nursing and Midwifery Council, General Medical Council, Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, to ensure that both the training curricula and continuing professional development requirements for all maternity staff include evidence-based learning on maternal health disparities, its possible causes, and how to deliver culturally competent, personalised and evidence-led care.[76]

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73 DHSC, Major conditions strategy: case for change and our strategic framework, updated 21 August 2023

74 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

75 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

76 House of Commons Women and Equalities Committee, Black maternal health, HC 94, 29 March 2023

Government response

The Government published its response (PDF) in June 2023.[77] It welcomed the committee's report and said it remained committed to tackling maternal inequalities and improving equity for mothers and babies.

The Government disagreed that a specific strategy for maternal health disparities was necessary, saying:

> The causes behind maternal health disparities are complex and embedded. Setting a concrete target for a specific health disparity does not necessarily focus resource and attention through the best mechanisms. We understand the significant and sustained action required—both within the healthcare system and across Government and wider society—but we do not believe a target and strategy is the best approach towards progress.[78]

The Government also said it would measure progress through metrics described in NHS England's guidance, Equity and Equality: Guidance for Local Maternity Systems.

Responding to the recommendation to review the training and professional development of maternity staff, the Government said that NHS England would carry out a scoping exercise to fully understand the implications of co-ordinating this review and determine how best to bring relevant stakeholders together.[79]

The Government also highlighted the role of healthcare regulators in setting standards for education and training and pointed out healthcare practitioners' existing access to cultural competence training.

Nursing and Midwifery Council response

The Nursing and Midwifery Council (NMC) published a response to the Committee's report.[80] The Council welcomed the report and noted its commitment to addressing discrimination.

The Council responded to some of the Committee's recommendations, including on education and training. The Council said it "strongly agree[s] that the maternity workforce must be properly equipped to understand and recognise disparities and apply this knowledge to deliver personalised, effective and respectful care".[81] The Council noted that "principles of

77 House of Commons Women and Equalities Committee, Black maternal health: Government Response to the Committee's Third Report, HC 1611, (PDF) 30 June 2023

78 House of Commons Women and Equalities Committee, Black maternal health: Government Response to the Committee's Third Report, HC 1611, (PDF) 30 June 2023

79 House of Commons Women and Equalities Committee, Black maternal health: Government Response to the Committee's Third Report, HC 1611, (PDF) 30 June 2023

80 Letter from the Nursing and Midwifery Council, relating to Black maternal health (PDF), published 6 September 2023

81 Letter from the Nursing and Midwifery Council, relating to Black maternal health (PDF), published 6 September 2023

inclusivity, person-centred care and cultural competence are already embedded in our Code and standards".[82]

The Council set out an expectation that Approved Education Institutions should provide learning opportunities for students to develop knowledge and skills in relation to complications and additional care needs, including how they relate to physical psychological, social, cultural, and spiritual factors. It also noted its work with the Royal College of Midwives in developing the Decolonising the Curriculum toolkit,[83] which was designed to support the diverse maternity care needs of all women.

[82] Letter from the Nursing and Midwifery Council, relating to Black maternal health (PDF), published 6 September 2023

[83] Royal College of Midwives, Decolonising midwifery, accessed 21 September 2023

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