National
Maternity and
Neonatal
Investigation

Independent Investigation into Maternity and Neonatal Services in England

Final report and recommendations

Contents

Note to reader: This report uses an additive approach to language. By this, we mean that the report seeks to centre the experiences of women and mothers, while also recognising that not everyone who is pregnant, gives birth or uses maternity and perinatal services identifies as a woman or mother. Further information on our approach to inclusive language and terminology is provided at Annex 1.

Foreword

Words cannot describe the pain, suffering and trauma I saw and heard time and time again when talking to women and families about their experiences of maternal and neonatal care in England. Anticipation and joy turned into pain, distress and trauma. Questions left unanswered. Responsibility and accountability denied. Not heard. Rebuffed. Dismissed. Ignored. Psychological harm repeated over and over with the constant retelling of experiences. And running through it all the feeling of justice denied, for self and for others. Because mistakes continued to be made. Learnings were not shared and the system did not change fast enough. I wanted to understand how this was still possible in England in the 21st century.

I hope that this report, given its systemic approach, has got to the source of the problem and that we can now make a concerted and urgent effort to make things right. Every avoidable death of a baby, a woman, is one too many. Every instance of avoidable harm is one too many. The emotional toll and cost to families is indescribable. As a country, as a community, we cannot continue like this. I hope the recommendations in this report will make a significant difference and will help us to put in place a maternity and neonatal service with safety, quality, equity and compassion at its heart and crucially one in which women and families have a voice.

In August 2025 I was asked to chair a rapid Investigation to understand why avoidable deaths and harm to women, birthing people and babies continue to occur, despite multiple reviews, inquiries and hundreds of previous recommendations across maternity and neonatal care. The need for this Investigation has never felt more urgent; the Ockenden Maternity Review recently published its findings on Nottingham University Hospitals NHS Trust, while the Thirlwall Inquiry is due to be published shortly and independent reviews into Leeds Teaching Hospitals NHS Trust and University Hospitals Sussex NHS Foundation Trust are in progress.

There is absolutely no justification for the tragic cases of unsafe care and avoidable harm we continue to see in England. Nor is it acceptable that so many women and families experience a poor response and lack of accountability when something has gone wrong. I have been determined to put women and families at the heart of this Investigation. I have also sought to identify the underlying causes of the problems experienced by them and present solutions which will improve the system. There are some fundamental aspects of these heartbreaking cases that appear repeatedly in this report: women and families not being listened to and dismissed; unacceptable racism and discrimination embedded within the system; a lack of connectivity between services; and a failure to place safety at the heart of the system.

As I set out in my December *Reflections and Initial Impressions*[1] publication, the problems that this Investigation has identified are not new: many have been reported on in previous reports. Indeed, the work we have undertaken since December has only reinforced those early impressions. What is different about this report compared to my previous reflections and subsequent *Interim Report,*[2] is that we have now 'joined the dots', which means that we can provide a set of recommendations about what needs to be done to change the system for the better.

It is clear to me that the maternity and neonatal system is not set up to deliver consistently safe, high-quality and compassionate care and this must be rectified. It is fragmented, overly complex and too slow to learn and improve. The consequences of this can be seen in the tragic experiences we hear about. The recommendations I have made should deliver long-term, sustainable change, create a system that learns from harm, and help women to receive safer care, justice and accountability in the future. I urge the Secretary of State for Health and Social Care to commit to implementation of all the recommendations.

My recommendations will drive change by creating a new statutory role of Maternity and Neonatal Commissioner, accountable to Parliament, who will be charged with having a relentless focus on improving maternity and neonatal care. Their primary role, in partnership with leaders in the maternity and neonatal system, will be to lead the redesign of the service, through a new 'Modern Service Framework'. The new Commissioner must lead work with system leaders to tackle fragmentation and unacceptable variation by setting clear minimum national standards for safety, putting in place effective governance and accountability structures. They must also ensure that the new Framework is designed in a way that ensures that the system consistently:

- Tackles critical safety issues, including those identified by this report which are to:
    - Listen to women, birthing people and families
    - Eradicate racism and discrimination
    - Develop a positive culture which prevents and tackles poor and unacceptable behaviour
- Apologises and acknowledges mistakes
- Improves leadership and culture
- Overhauls estates and IT
- Tackles workforce pressures
- Designs safe services
- Transforms processes if things go wrong to embed accountability.

By their nature, recommendations focused on system change can feel bureaucratic and technical and it will take time to effect the change that is desperately needed. However, the evidence is categorical: system change leads to real reductions in harm and poor experience for everyone who uses the system. I have also identified a number of actions that can be taken now, and which will make a difference straight away. The most critical of these actions is for NHS trusts to urgently review their triage process, which is where women are assessed, over the phone or in person, when they contact maternity services because they have a concern about their pregnancy. In reality, this is increasingly becoming the A&E service for maternity, where the early warning signs of problems can, and should, be spotted. However, from what we saw and heard, the triage process is not fully resourced or prepared for this purpose. Nowhere was it more apparent that the voices of women, birthing people and families were ignored or dismissed than in the triage process. We know that NHS England (NHSE) will shortly publish the first national maternity triage specification to set out what good maternity triage services look like and I welcome this. My assessment is that if triage services are improved, lives will be saved and harm reduced.

Delivering change at the scale and pace demanded requires political will, consistency and pressure, commitment to system redesign and a cultural shift at national, regional and trust level. As has been said in relation to many intractable problems in institutions, ‘culture eats strategy for breakfast’. By which I mean, no matter how insightful or detailed an improvement strategy is, its success depends on the people executing it and the environment they are operating in. I urge all future Secretaries of State and the National Maternity and Neonatal Taskforce to keep a focus on ensuring that the conditions for successful implementation of my recommendations are in place.

This Investigation has been a huge undertaking and of significant scope. To provide a full diagnosis of the systemic problems, we have put the voices and experiences of women, birthing people and families at the centre of our work. We have listened directly to over 450 families from across the country and received over 10,500 responses to a public Call for Evidence, ensuring their perspectives shape our understanding and recommendations. To fully reflect the experiences of those receiving and providing care, we also visited 12 local NHS trusts and heard from over 9,000 staff through surveys, site visits and one-to-one discussions. The findings of the Investigation’s public Call for Evidence and workforce survey have been published alongside this report in the Supplementary Evidence - Public Call for Evidence and Supplementary Evidence - Workforce Survey documents.

In addition, we engaged with advocacy and campaigning organisations, national stakeholder groups and leaders in the NHS through formal evidence sessions to ensure a comprehensive and inclusive view of maternity and neonatal care. We also carried out a review of previous recommendations in maternity and neonatal care (included at Annex 3), and the World Health Organization (WHO) European Observatory on Health Systems and Policies provided inputs into international comparisons and different health systems. This information has been published alongside this report in the Supplementary Evidence - International Comparisons document. Through our methodology we have collected the evidence needed to underpin the conclusions we make.

This final report with recommendations is the result of an intense, collective effort. I have been supported by the insights and expertise of Expert Advisors, who have been engaged in all aspects of the Investigation and have worked with me to develop and hone the recommendations in this report. The Advisors are drawn from the professions which need to work together to implement the recommendations: midwives, obstetricians, neonatologists, anaesthetists and public health experts.

After what has been discovered through this Investigation and with the spotlight currently shining on the mistakes and inequities in maternity and neonatal care, I have been asked whether women and families should trust their local services. I am acutely aware that many people reading this report may be pregnant and anxious about whether they will encounter some of the same problems I describe. The vast majority of pregnancies and births in England have a positive outcome and we have seen many examples of good practice with staff going the extra mile. I do not want to discourage anyone from getting pregnant and having a baby. I want that experience to be positive and safe.

A huge thank you to the family members who took the time to share their experiences with me and my Investigation team, whether verbally or in writing. We have heard heartbreaking testimony from women, birthing people, fathers, partners, family and friends; I still find it shocking that women and babies have been harmed or have died, sometimes as a result of failings in the maternity or neonatal care provided. We are a wealthy country. It should not happen. We heard from families who have lost friends or family members who were new parents or parents-to-be in tragic circumstances. It has taken courage to repeat painful and traumatic experiences. Some families told us they were prepared to share these experiences so as to prevent this happening to anyone else, ever again. Every experience shared has been invaluable in helping us think through how best to frame our findings and recommendations. Thank you again. I am mindful, and have been throughout, that our learning should not come at the expense of your pain.

I would also like to acknowledge those families and organisations who spoke to us and provided written evidence about specific health conditions which can arise during, or influence, pregnancy and birth. While it has not been possible for this review to address the detail of each individual example, and doing so would have been beyond our scope, the evidence you provided has been indispensable in developing the national recommendations which you will find in this report.

I would like to express my gratitude to the members of the maternity and neonatal workforce who took the time to submit evidence, share their experience and provide valuable insights throughout this Investigation. So many of you told us about your commitment to providing safe, high-quality care to all women and families who use maternity or neonatal services, and the things that hold you back from doing so.

I am also grateful to the stakeholder organisations, advocates, MPs and national leaders who have contributed to the Investigation by sharing research, data and experience. Your readiness to provide insight and expertise has been extremely helpful.[i]

And finally, my team. I would not have been able to complete this Investigation without the support and commitment of my Expert Advisors and my Investigation support team. We challenged each other to be bold. I hope we have delivered that boldness. Thank you for your professionalism, compassion, support and dedication.

Valerie A

Baroness Valerie Amos

Chair of the National Maternity and Neonatal Investigation

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[i] A full list of individuals and organisations that have contributed to the Investigation can be found at Annex 5.

Executive Summary

Note to reader: While the term 'maternity care' is widely understood, the inclusion of 'neonatal care' within this report requires clarification. Our local investigations included visits to neonatal units providing special, high-dependency and intensive care, where we spoke with staff and parents; however, the 'neonatal care' considered here refers specifically to care delivered within a maternity setting, either in inpatient wards or in the community, with the aim of avoiding unnecessary separation of mother, parent and baby. This includes immediate support at birth (such as resuscitation), neonatal transitional care delivered in partnership with neonatal clinicians, palliative care for babies with life-limiting conditions, and support from Neonatal Community Outreach Teams for babies with additional needs. All of these elements can be delivered within maternity services and should be considered as part of the Modern Service Framework we are recommending.

Introduction

Having a baby should be one of the happiest moments of a family's life. For most women in England, it is. But for too many (depending on where they live, who they are or simply the day they give birth), the care they receive is not good enough and can result in avoidable harm for women, birthing people and babies. This report sets out what needs to change and why it cannot wait. The objective is simple: a maternity and neonatal system that delivers consistently safe, equitable and compassionate care and gives all women, birthing people and babies the high-quality care that they need at the time they need it. From the evidence gathered throughout this Investigation, it is clear that delivering this objective is easier said than done and, when it goes wrong, there can be devastating consequences for women, babies and families. There have been some improvements in recent years. For example, stillbirth and neonatal mortality rates are at or close to historically low levels, although there has been comparatively little progress since 2020.[3] During our Investigation, we saw some examples of good practice such as the Family Integrated Care (FICare)[4] model in neonatal services, which facilitates families becoming the central care givers with support from nursing and medical staff, and examples of improvements to bereavement care facilities to support families in the most challenging times.

What did we do?

Since last September, we have carried out a significant and wide-ranging programme of work, which I briefly summarise below. All of this activity was underpinned by a robust investigation methodology, which we have provided at Annex 2. We engaged with over 450 families in person and over 10,500 women, birthing people and families responded to our public Call for Evidence (further detail is provided in our methodology). We heard from over 9,000 staff through surveys, trust visits and one-to-one interviews. I know that some families did not want me to focus on staff experience, as they felt that this would take attention away from the loss and harm they have suffered, but real, sustained change will only happen if staff see themselves as part of the solution and are supported to do so. The majority of staff are committed to delivering high standards of care. My findings are grounded in the reality of what we heard from families and the day-to-day working lives of staff who deliver the services they rely on. We also interviewed over 40 national leaders and held evidence panels with national organisations to understand what, from their perspective, was going wrong and what they thought could be done to address the challenges.

In addition to this engagement, my team has: analysed huge amounts of data and documents (we received over 9,500 pieces of evidence); undertaken a review of previous recommendations (to try to understand why previous reviews have not been implemented and, where they have, why change has not been sustained); and reviewed examples from other countries. We also considered the findings of the Wales maternity and neonatal assurance assessment, which took place between September 2025 and February 2026.[5] To identify the system issues that are of concern across the country, we visited 12 local NHS trusts, chosen on the basis of a range of factors, including variation in geography (both rural and urban), socio-economic factors, trust type, case mix and feedback received from families. In visiting trusts, we did not seek to replicate the types of investigation undertaken by the Care Quality Commission (CQC), the regulatory body for maternity and neonatal services. We wanted to see, sense and feel what was happening on the ground. Our trust reports are a ‘snapshot’ in time. This was vital to fully understand the complexities and differences in maternity care across England.

The initial timescale set for the Investigation was six months, but it was not possible to meet this given the scale of the work required to do a comprehensive report and cover the range of issues raised. We needed to analyse an unprecedented amount of evidence, interrogate the nature and extent of the problem, and take the time to get the recommendations right.

What concerns did we hear about?

- **Women and birthing people not being listened to, heard or believed,** which can have serious consequences for the safety and quality of care they receive, resulting in avoidable harm, trauma and loss of confidence in themselves and in the system.
- **Racism, discrimination and structural inequalities embedded throughout the maternity and neonatal system,** with profound implications for outcomes and the quality of care women and babies receive. It also has a significant impact on staff wellbeing and the safety culture of the workplace.
- **Services not designed in a way that ensures consistent safety.** Instead, services have evolved over time in an unplanned, reactive and piecemeal way, with limited ability to see or predict trends. The design of services and approach to planning is

not responsive to the changing needs of women, birthing people, babies and families including the changing profile of women and those giving birth and the increase in medical interventions during births.

- **The system is fragmented and care is inconsistent.** Public health and preconception care, general medicine and surgery, mental health, antenatal, labour and birth, neonatal and postnatal services are not joined up. Some services are too often deprioritised when there are pressures elsewhere in the system, including postnatal care and community services. Clear guidance already exists about the type of service to be delivered to women and families through the core maternity and neonatal pathways, but this is not always being followed in practice.[6] [7] [8] This makes the system confusing, inflexible and unresponsive to women and families. Team working between different professional groups – including midwives, obstetricians, anaesthetists, primary care and general medicine specialists, and neonatologists – is inconsistent and not always effective.

Women, birthing people and families told us about:

- *Not being listened to, heard or believed, meaning they had:*
  - Been dismissed when raising concerns, leading in some cases to avoidable harm or unsafe care
  - Not been treated with kindness or compassion consistently
  - Experienced staff disagreeing with each other rather than listening to and communicating with them about what was happening
  - Not been able to give informed consent to medical procedures, due to poor communication and lack of information
  - Suffered pain and distress during a caesarean section or assisted vaginal birth due to inadequate anaesthetic block.
- *Experiencing racism and discrimination, including:*
  - Receiving unfair or unequal treatment, leading to delays, unsafe care with, at times, devastating outcomes
  - Being subjected to stereotyping and racial slurs, Islamophobia and Antisemitism
  - Reluctance to engage with maternity services following previous racist or discriminatory experiences.
- *Services that were not designed to ensure consistent safety, resulting in:*
  - Avoidable harm and lifelong trauma

  - A lack of accountability from trusts when things had gone wrong, with families finding it hard to get answers about what had happened to them and their baby or assurances that lessons would be learned
  - Care in poorly maintained and, at times, unsafe clinical environments
  - Lack of space for partners and families.
- *A fragmented system and inconsistent care, including:*
  - Significant variation depending on location, the person receiving care, or the type of service provided.
  - A lack of connectivity between General Practitioners (GPs), antenatal and post-natal care, sometimes not being able to get help from any service.
  - Having to repeat, sometimes very traumatic, information time and time again, to different people across different settings.

National leaders and stakeholder organisations reinforced the themes of safety, fragmentation and inconsistency and described a maternity and neonatal system in which there is:

- Fragmented governance, with too many organisations, an abundance of overlapping recommendations to be implemented, an overwhelming amount of guidance, unclear lines of responsibility and inadequate regulatory oversight for ensuring safety and change.
- A lack of clarity on review processes, with variable quality of local reviews into safety concerns, inconsistent specialist input, limited follow up on actions, and slow or no detection of emerging risk by the wider maternity system.
- Outdated service models, with service planning with staffing assumptions that no longer match rising complexity, individualised care planning, intervention rates or specialist demand.
- Persistent workforce pressures, with shortages, attrition, rota gaps, high absence rates and too little protected time for training, learning and improvement.
- Fragile education arrangements, with uneven educator capacity, and insufficient multidisciplinary training.
- Challenging cultures, with fear, staff feeling blamed, hierarchical structures, inequity in leadership structures, racism and discrimination undermining speaking up, teamwork and learning.
- Poor integration and transitions between maternity and neonatal care and, following discharge, a lack of family voice, outreach services and inconsistent postnatal support across the country.

- Poor infrastructure, with, at times, unsafe and unacceptable estates, limited capital investment, weak digital systems that lack interoperability to aid clinical care and too little (political) backing for difficult reconfiguration decisions.
- Adversarial responses after harm, with complex complaints routes, unclear accountability and too little openness, lack of apology and engagement to repair trust.
- Multiple reviews having an impact on staff morale, confidence and wellbeing as well as recommendations from those reviews that are too numerous, not evidence-based, poorly prioritised, insufficiently funded or not funded at all and not backed by clear oversight or evaluation through funded research.

Staff evidence also reflected these themes and staff explained that they:

- Felt ignored and dismissed when they raised concerns about whether they could provide a safe or joined-up service or flagged excessive workload pressures.
- Experienced racism, both from other staff and from women, birthing people and families.
- Worked in poor-quality and sometimes dangerous clinical environments, often working long shifts without breaks, in areas lacking appropriate spaces for staff to rest.
- Experienced a lack of visible leadership and direct support in clinical areas when they were too stretched to deliver high-quality care.
- Had not received sufficient training or did not have protected learning time to deliver their roles effectively.
- Believed the system was not set up to allow them to care for women adequately, with staff experiencing trauma and moral injury from failures in care.
- Felt demotivated and overwhelmed by a seemingly endless volume of paperwork: time spent preparing business cases for service developments that should be essential and established; complex Information Technology (IT) systems; regulation and bureaucracy; and the pressure of multiple investigations, inspections, recommendations and action plans (all of which they described as preventing them from delivering person-centred care).
- Experienced poor working culture, including being fearful of being blamed when things went wrong, with a strong sense that senior leaders did not take responsibility and were not accountable.

What is the wider context?

Maternity and neonatal services are not operating in a vacuum. The profile of women and birthing people using maternity services looks very different from a generation ago.

Women are giving birth at older ages, with an increased prevalence of some pre-existing medical conditions. We have also seen a substantial increase in clinical intervention during labour and birth. Rates of induction of labour have risen considerably, as have caesarean section rates.[9] These changes have already had an impact on safety and service delivery and will continue to have profound implications for how maternity and neonatal services are designed. We must seek to understand the multiple drivers for this rise in caesarean birth, as we see current trends indicating further increases are possible in the future.[10] The changes outlined above require a fundamental rethink of staffing structures, estate use, and how different parts of the service connect. We heard about a system under chronic pressure, not because of any single failure, but because it is not designed for this different context.

The system is also affected by society's attitudes: to women, including misogyny; to Black and Asian people; to people from other non-white racial backgrounds; to people with mental health challenges; to people with disabilities; and to LGBTQ+ families. Widening inequalities arise from the social determinants of health, including poverty and socio-economic disadvantage; the changing healthcare policy landscape; and the impact of previous investigations and reviews of individual maternity services in England and their recommendations. These all play a part in a system straining under pressure, no longer designed for the maternity and neonatal needs of today or the future.

What needs to happen?

The work of this Investigation has led us to the conclusion that the maternity and neonatal system needs urgent reform, putting safety at its centre and embedding listening to women and anti-racism and discrimination practice at every level.

We need to move to a maternity system that is designed to meet the needs of women, birthing people and families, that meets this rising demand safely, and is based on a system design that is constantly learning and responding to real-time monitoring data. A system that listens to the women, birthing people and families who use and rely on it. A system that is designed to meet national standards and reduce local variation. A system that provides continual assessment of safety processes rather than relying on retrospective data. A system that prioritises action learning.

Set out below are eight recommendations to deliver this reform. These tackle the cultural and structural problems facing the system and will deliver fundamental change. Action is recommended in the following areas:

1. Creating a statutory national Maternity and Neonatal Commissioner to drive the urgent, systemwide change identified by this Investigation and provide the oversight to drive accountability and implementation of a redesigned maternity and neonatal system. The legislation for the Commissioner must be included in the Health Bill currently in Parliament.

2. Systematically listening to the voices of women, birthing people and families.

3. Improving how the system responds and learns when something goes wrong.
4. Creating a Modern Service Framework which sets out national standards to consistently achieve high-quality maternity and neonatal care.
5. Tackling racism, discrimination and inequality.
6. Improving system governance and accountability structures and regulatory oversight.
7. Improving culture and teamworking, and strengthening leadership at all levels of the system and across professions.
8. Delivering estates and digital systems that are fit for modern maternity and neonatal care.

As I said in the Foreword, the scale of the actions required by my recommendations will take time to implement. However, I have also identified actions that can start now which will make a significant difference to the experience of women and families and the ability of staff to provide safe care. I particularly want to emphasise the importance of NHS trusts urgently reviewing their triage process, where women and birthing people are assessed when they have a concern about their pregnancy. Other actions include guidance for situations where women decline the clinical care that is recommended for them; the government responding to the 2019 consultation seeking views on introducing coronial investigations of stillbirth cases in England and Wales[11]; and consideration of the benefits and drawbacks of an alternative compensation system for adverse events in maternity and neonatal services.

This Investigation highlights clear opportunities to strengthen the quality, safety and consistency of care across maternity and neonatal services. There is already significant work going on in some of the areas we identify as needing attention. Where possible, we have identified how to build on existing work so as not to ‘reinvent the wheel’. The findings and recommendations set out a clear direction for change, focused on improving outcomes and experiences for women, birthing people and their families. Successful delivery will require sustained leadership both nationally and locally, collaboration and a whole-system commitment to learning and improvement. We look forward to seeing the timely implementation of these changes and the continued evolution of maternity and neonatal services to ensure they are of the highest quality, responsive, person-centred, seamless and fit for the future.

Recommendations

These recommendations aim to address the systemic problems identified in this report. If they are delivered in full, our assessment is that the overall safety and quality of maternity and neonatal care in England will be materially and sustainably improved.[ii]

1. **The Department of Health and Social Care (DHSC) must create a statutory Maternity and Neonatal Commissioner, introducing legislation into the Health Bill at the earliest possible opportunity, and appointing a Commissioner within six months of Royal Assent.**

To drive the urgent, system-wide change identified by this Investigation, DHSC should establish a new, statutory Maternity and Neonatal Commissioner to provide the leadership and oversight needed to drive accountability and implementation of a redesigned maternity and neonatal system. The Commissioner will:

- Hold the system to account for delivering improvements and implementing the Investigation's recommendations.
- Drive oversight of a redesigned maternity and neonatal service through the mechanism of a new Modern Service Framework (see recommendation four below).
- Champion the voices of women, birthing people and families, ensuring their feedback is at the heart of the maternity and neonatal system.
- Co-chair the National Maternity and Neonatal Taskforce, alongside the Secretary of State for Health and Social Care.
- Report on progress every six months to the Health and Social Care Select Committee and annually to Parliament. DHSC must provide a full response to these reports within three months of publication.
- Report to families on an annual basis.

2. **DHSC, NHSE, Integrated Care Boards (ICBs) and NHS trusts must take action to listen to the voices of women, birthing people and families <u>within 12 months</u>.**

Listening to the voices of women, birthing people and families using maternity and neonatal services is vital to safety and improving outcomes. In addition to continuing to pro-

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[ii] The Investigation is aware that the government intends to abolish NHSE in 2027 via the Health Bill, subject to Parliamentary approval. NHSE was still operational at the time of writing this report and so is included in these recommendations where relevant.

gress existing initiatives underway in support of this aim, including the rollout of the Patient Reported Experience Measure (PREM) tool for maternity and neonatal services, we recommend the following actions:

- Treat listening to, hearing and acting on the voices of women and birthing people as a critical safety issue. This means that at trust level, data on listening to women must be captured as safety intelligence, reviewed through patient safety governance, escalated to board level where patterns emerge and linked to measurable improvement action. It must also be considered by regulators as part of their assessment of service safety.
- Enhance the existing maternity pathway by ensuring that:
  - Continuity of carer is provided for all scheduled antenatal and postnatal care
  - Every health professional moves away from a fixed risk categorisation for women and birthing people at the start of pregnancy as ‘high risk’ or ‘low risk’ with risk being dynamically assessed at every scheduled appointment
  - A postnatal debrief discussion is offered to every woman and birthing person, by a midwife or appropriately trained clinician.
- Enhance the existing neonatal pathway by ensuring that:
  - Transitional care and neonatal community care services are available to all families in order to keep mothers and babies together and avoid unnecessary admission to all types of neonatal unit
  - A standardised neonatal palliative care service model must be in place for all families when needed, ensuring that they are heard, informed and that palliative care is planned with families.
- Embed trauma-informed principles across maternity and neonatal care as routine practice. This includes expanding provision of trauma-informed psychological support to families as a matter of routine practice after experiencing harm in care. Trauma-informed psychological support must be clearly demarcated as distinct from bereavement support.
- Commission and deliver antenatal education that reflects the realities of pregnancy and birth today, including induction of labour, caesarean births and pain relief. To facilitate inclusivity, proactive contact must be made with women and families, particularly those from more disadvantaged backgrounds. This education must be redesigned in partnership with women, birthing people, families and staff.

3. **DHSC, NHSE and CQC must drive improvement, within 12 months, of the quality, transparency, oversight and accountability of investigations and ensure learning is captured and acted upon when things go wrong.**

When death or harm occurs families should be offered a full explanation of what happened. There is an imbalance of power between trusts and families and the resources available to them, which can prevent families from receiving the answers they deserve when things go wrong. Greater clarity regarding how all investigation pathways should be delivered is required, along with an improvement in investigation expertise. To address this, we recommend that:

- If, after all trust reviews and investigations have been completed, families are not satisfied with the answers they have received, families must have the right to request that a trust commissions an independent investigation of the circumstances of their individual case.
- The pathways and processes for investigating when things go wrong should be clearly communicated to families, including providing details about: how families will be involved and updated; how investigations will be led; what external scrutiny is required; and what timeline families can expect.
- All current investigation types must include independent challenge at every stage, which must be explicitly stated in policy and operational documents.
- A national specialist training programme must be designed and rolled out to equip all investigation staff with the skills and protected time needed to carry out reviews and investigations to a consistently high standard and communicate compassionately with families and staff.
- Learning from investigations and reviews must be systematically shared at national and regional level with robust quality assurance, and oversight of the implementation of all recommendations arising from investigations must be strengthened at local, regional and national level.
- The health and social care regulator, CQC, must include the assessment of the quality of investigations in their regulatory framework.

4. DHSC/NHSE must design a Modern Service Framework for maternity and neonatal services <u>within 12 months</u> and begin rollout <u>within 18 months</u>.

The maternity and neonatal service model needs to be redesigned to consistently achieve high-quality maternal and neonatal care: improving outcomes, meeting core safety standards and ensuring excellent family experience, which meets the demands and requirements of a modern service.

We recommend:

- The Modern Service Framework takes a safety systems approach to design a set of national standards which will deliver responsive, safe and improved services and outcomes across the whole care pathway – from preconception care to postnatal and neonatal care, including investigations and reviews when things go wrong. The Modern Service Framework must shift the maternity service to a more agile design which can respond to the demands of both planned and unplanned (urgent and emergency) care. This must be developed in collaboration with women, families, staff and experts.

- Maternity triage must be formally designated as a safety-critical clinical environment, with binding national standards rather than guidance.
- A set of unified national standards for clinical, professional and operational guidance for maternity and neonatal services must be produced. This must be developed in partnership with national professional organisations, including the National Institute for Health and Care Excellence (NICE), Royal Colleges and professional bodies.
- A redesigned workforce model must be developed and implemented, underpinned by a new multidisciplinary workforce tool for maternity and neonatal services. This must include:
  - Specific consideration of the need for obstetric consultants and anaesthetists to be available on a delivery unit for timely critical senior decision making and intervention 24 hours a day, seven days a week and a formal review of rota models. In the interim, trusts must mandate adherence to current Royal College of Obstetricians and Gynaecologists (RCOG) guidance on consultant and senior presence in and out of hours.
  - Balancing the skill mix of midwives across the 24-hour period, ensuring care is not compromised when specialist midwives are unavailable and that senior midwifery staff are supported to remain visible and clinically active alongside their managerial responsibilities. This must take into account the need to support midwives with career progression.
  - Developing the workforce model in collaboration with midwives, obstetricians, neonatologists, anaesthetists, Directors of Public Health and others.
- DHSC/NHSE must review the optimal size and configuration of maternity and neonatal units to deliver reliable safe care. Neonatal Operational Delivery Networks (ODNs) should match geographically with NHS regions. This should include consideration of whether neonatal and maternity services should be commissioned together.
- DHSC/NHSE must ensure that existing research funding is targeted at the issues where an improved evidence base will support delivery of the new Modern Service Framework. This must include:
  - An independent study of the accuracy of different growth charts available for measuring fetal growth and their ability to reduce adverse outcome.

  - Ensuring there is a sound evidence base when implementing new policies and guidance. This should include stopping mandatory initiatives which lack evidence and feasibility.

5. **DHSC, NHSE, ICBs, NHS trusts, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) must treat racism, discrimination and inequality as a critical maternity safety issue – within 12 months, with work starting immediately.**

Racism and discrimination, whether overt or structural, whether experienced by those receiving care or by the staff providing it, are not peripheral concerns to be addressed through occasional training or local initiatives. As Lord Darzi said: "*The impact of the deterioration in access and the challenges around quality of care have not been felt equally. As we have seen, there are important disparities in almost all aspects of care. The 'inverse care law' seems to apply: that those in greatest need tend to have the poorest access to care*". In addition to accelerating delivery of existing work underway in this area, led by the NHS Race and Health Observatory, we recommend that:

- Racism and discrimination must be treated as a critical safety issue requiring urgent intervention. This means that at trust level, where inequalities in access, experience, safety or outcomes are identified, data must be captured as safety intelligence, reviewed through patient safety governance, escalated to board level where patterns emerge and linked to measurable improvement action. It must also be considered by regulators as part of their assessment of service safety.
- An independent evaluation of anti-racism training currently being delivered across maternity and neonatal teams is commissioned by DHSC/NHSE, assessing quality, consistency, and measurable impact on staff behaviour and patient experience. The findings should be used to establish a national minimum standard for mandatory training.
- Trusts must take immediate action to collect, analyse and act on the most granular data their systems allow, using this to identify inequities in access, experience, safety and outcomes, and to target service improvement without stereotyping or attributing risk to communities themselves.
- DHSC should explore reviewing and reforming the data categories used across health datasets, to ensure they reflect the true diversity of the women and babies being served.
- The GMC and NMC should keep referrals from trusts under review to identify potential racial bias and discrimination. They must alert relevant trusts to any concerns identified, which must be investigated.

6. **DHSC/NHSE must clarify existing system governance, oversight and accountability structures and improve the effectiveness of regulatory oversight within nine months.**

To enable the success of the new Modern Service Framework, a streamlined, national oversight and leadership model must be put in place so that clear lines of governance, accountability and escalation are in place at all levels of the system. Steps must be taken immediately to improve the regulatory oversight provided by CQC and other relevant bodies.

To do this, we recommend that DHSC/NHSE must:

- Lead work to ensure that the organisations responsible for maternity and neonatal services work together to clarify responsibilities, remove duplication and improve effectiveness. This includes, as a minimum, CQC and professional regulators such as the GMC and NMC, alongside professional bodies including the Royal Colleges.
- Work with CQC to improve its effectiveness immediately and start work to put in place a specialist regulatory unit, with a sufficiently sensitive methodology, to provide regulatory assessment for maternity and neonatal services. This unit must include clinicians from a range of professional backgrounds to ensure the most recent clinical perspectives are fully integrated into the regulatory function. The methodology must put the views of women and families at its centre and be kept under regular review.

7. **DHSC, NHSE, ICBs and NHS trusts must work with colleges, universities, postgraduate educators and others to improve culture and teamworking, and strengthen leadership at all levels of the system and across professions within 12 months.**

Strong, supportive, visible and approachable leadership and teamworking across professions from teams/ward, to board, to DHSC is essential for delivery of objectives, staff morale and confidence and creating the right culture and leadership structures to enable staff to provide safe and compassionate care. Poor behaviour (including bullying, racism and discrimination) by leaders and senior clinicians has an impact on safety and must be tackled by trust leaders. We recommend that:

- Developing a positive culture which prevents and tackles poor and unacceptable behaviour should be treated as a critical safety issue. This requires good teamworking with common objectives. Any barriers must be identified and measures taken to address poor and unacceptable behaviour, including group training, team development, staff welfare and psychological support. Reports of poor and unacceptable behaviour must be captured as safety intelligence, reviewed through patient safety governance, escalated to board level where patterns emerge and linked to measurable improvement action. It must also be considered by regulators as part of their assessment of service safety.

- A review of obstetric clinical director and senior medical posts must be undertaken by DHSC/NHSE, including how these posts can be established as substantive posts, which become a desirable subspecialisation in clinical management and support progression to senior obstetric posts. These roles should be given sufficient time, training and administrative support.
- All trusts must ensure there is parity between midwifery, obstetric and neonatal leads at every reporting level, including a senior obstetric clinical lead working alongside the Director of Midwifery in each provider. Matched clinical obstetric and midwifery consultant lead roles must be in place to support joint care planning for services and women clinically. These posts must have a primary focus on safe, evidence-based care, separate from operational management of the units. At board level, the Chief Medical Officer for the trust must consistently engage on maternity and neonatal care issues alongside the Chief Nurse.
- A fundamental review of undergraduate and postgraduate education must be undertaken to include development of interconnected curricula and opportunities for shared learning and ongoing multi professional training for all professional groups (midwifery, neonatal and medical) to support joined up care planning.
- Education and training for all clinicians — at every stage of their career — must place trauma-informed care, bereavement care, compassionate care, communication, teamworking and response to adverse events at its core.

8. **DHSC/NHSE must deliver estates and digital systems that are fit for modern maternity and neonatal care with 12-month, five-year and 10-year investment commitments and implementation deadlines.**

The physical environments in which women give birth and babies receive their earliest care must be safe, protect privacy and be in acceptable condition. Estates and digital infrastructure are the foundations of safe care, and they have been eroded by sustained underinvestment.

We recommend:

- Clear, enforceable standards for estates must be set out in the Modern Service Framework. Health Building Notes (HBNs) 09-02 and 09-03 for Maternity Care and Neonatal Facilities, published in 2013, are no longer fit for purpose and must be comprehensively revised within 12 months. Updated standards must reflect the operational realities of modern service delivery, mandating safety for women, families and staff at all times. The government must set out 12-month, five-year and 10-year investment plans for long-term capital investment. These should deliver the revised standards for new and existing estates, including tackling the immediate maintenance and refurbishment backlog. The 12-month, five-year, and 10-year investment commitments must be published and subject to parliamentary oversight.

- A clear national implementation timeline must be set for the rollout of interoperable digital maternity and neonatal systems across all providers, including defining, mandating and collecting clear national datasets, to ensure that every woman and baby has one single, digital record that follows them wherever they receive care. This should include consolidation of one unified national data set for maternity and neonatal care, which also includes public health and epidemiological data, made available in a simple format in order to identify trends and monitor performance. Digital investment must also extend to emerging technologies that support the quality and safety of clinical interactions.

What can be done now?

The scale of the actions required by these recommendations will take time to implement. However, there are a set of actions that can start now which will make a significant difference to the experience of women and families and the ability of staff to provide care.

- DHSC must take immediate action to legislate for the role of the new statutory Maternity and Neonatal Commissioner through the Health Bill currently in Parliament.
- We are aware that NHSE are developing a national maternity triage specification, to set out what good maternity triage services look like. In 2023, RCOG produced a good practice paper, which established maternity triage as the critical *"emergency portal"* for unscheduled care. We recommend that NHSE ensures that the national maternity triage specification includes the following actions as a minimum:
    - Dedicated midwife resource must be available to answer calls and provide timely advice. For telephone triage services, staff must offer a face-to-face appointment if women remain concerned.
    - Appropriate clinical capacity and escalation pathways to maintain patient flow must be available at all times of day and night and at weekends. This will include access to a senior clinical decision maker.
    - Clear board oversight must be in place within trusts about the operation of the triage service, including regular reviews of waiting times, performance and implementation of actions to improve the service where identified.
    - Ensure units have sufficient antenatal bed capacity to admit women for support in early labour.
    - Within 12 months, an evidence-based tool should be mandated as the national triage standard across all NHS maternity units, with compliance monitored

  through regional and national maternity safety oversight. Compliance must include verification that the staffing and physical conditions required for safe implementation are in place; adoption of the tool without the infrastructure does not constitute compliance.

  - All maternity units to have dedicated triage staffing structurally independent of labour ward midwifery numbers. Redeployment from triage to labour ward to be formally classified as an escalation event requiring documentation and review. Triage midwives should be sufficiently trained in rapid assessment.
  - A national training pathway for midwives working in triage should be developed, enabling advanced practice, with clear competency frameworks and governance.
  - Triage performance data (including time to initial assessment, review times, redeployment frequency, and outcome data for women who experienced delays) to be collected, reported, and published at trust, regional, and national level quarterly, as a board-level patient safety indicator.

- In the interim, all trusts must complete a board-level audit within the next three months of current triage provision, taking account of the points above and with particular attention given to staffing, including medical staffing at appropriate seniority 24 hours a day, 7 days a week. The results of this audit must be reported to regions and DHSC/NHSE.
- Increasing numbers of situations in which women decline recommended clinical interventions or choose birth outside existing clinical guidance present a significant and evolving safety, ethical and legal challenge. National guidance must be produced, led by DHSC/NHSE, to support respectful, rights based, clinically safe care, including clear guidance on consent, risk communication, escalation, documentation and professional responsibilities.
- The government must publish the response to the consultation which was held in 2019 seeking views on introducing coronial investigations of stillbirth cases in England and Wales. This must be done in the context of any wider changes made to the investigation system, which we set out in recommendation 3.
- DHSC/NHSE must commission and publish a report to examine the benefits and drawbacks of an alternative compensation system for adverse events in maternity and neonatal services. This alternative system would aim to promote less adversarial relations between trusts and harmed and/or bereaved families and promote better learning from adverse events.

How did we get here?

The changing context of maternity and neonatal care

The maternity and neonatal system is operating in a markedly different environment today compared with even a decade ago. The demographic, social and health profile of women using maternity services has changed over time, reflecting wider societal and national trends in public health. The average maternal age has increased and there has been a rise in the prevalence of some pre-existing health conditions. The maternity and neonatal system has always served a diverse population with varied and complex needs. Socio-economic status, ethnicity and wider gender inequalities all play their part in shaping every woman's experience of maternity and neonatal care. Further evidence to demonstrate these and other trends in maternity and neonatal care has been published alongside this report in the Supplementary Evidence Data Annex document.

The recently renewed Women's Health Strategy for England[12] starts with these words: *"The NHS has a problem with basic, everyday sexism and an appalling culture of medical misogyny"*. We saw the impact of medical misogyny throughout this Investigation, leading to an embedded culture in which women's voices are ignored. And other factors play their part. Women and babies living in the most deprived areas in England are more likely to die. They have consistently higher levels of adverse outcomes including maternal and perinatal mortality. Deprivation can influence outcomes through a wide range of mechanisms, such as social and material circumstances, physical and mental health and access to preventative healthcare.[13] [14] [15]

That is why taking a joined-up approach to managing each and every person's healthcare is so important. The maternity and neonatal journey encompasses pre-conception care, which includes primary care and public health, antenatal care and post-natal care, and the care in the first several weeks after a baby's birth. That is why public health campaigns such as those focusing on the importance of women and birthing people not smoking or drinking alcohol during pregnancy, healthy weight support, perinatal mental health services and community-based services such as health visiting and wider early years support play such a vital role. We heard of examples where these services had been scaled back, meaning women and birthing people struggled to get the end-to-end care they needed.

We were struck by the extent of the underinvestment in perinatal mental health services and the impact of this underinvestment.[16] It is estimated that perinatal mental health issues affect around 26% of women,[17] with maternal suicide the leading cause of death for women between six weeks and one year after the end of pregnancy. Whilst access to specialist perinatal mental health support has improved, there remains unmet need.[18] [19] Maternal suicides often follow long periods where distress is not recognised or acted on, even when women are in contact with public services. Experiences of trauma during pregnancy, birth or the postnatal period can persist for many years, affecting daily life, relationships and future reproductive choices. Whilst all women and birthing people need support before they reach crisis point, those who are bereaved, facing poverty, racism, trauma, domestic abuse or previous poor care may need additional support to access and engage with mental health support. The complexity and scale of this issue could not be fully explored within the timeframes of this rapid investigation. It should be looked at further by the Maternity and Neonatal Taskforce.

Maternity and neonatal care sits within a wider health and care system that is trying to deal with growing complexity and the ongoing impact of COVID-19. Services are expected to provide care that is safer, more personalised, joined up and fairer for all, while managing pressures on funding, staffing and infrastructure.

Lord Darzi's Independent Investigation of the NHS in England[20] (2024) described a system that has received too little capital funding for estates and IT infrastructure, with outdated estates, obsolete digital infrastructure and constrained capital spending directly undermining productivity, safety and care quality. These structural and system-wide constraints continue to shape what services are able to deliver and are examined in more detail later.

An added element of the contextual challenge is the difficulty of making change happen. Maternity and neonatal services have been the subject of sustained national attention and scrutiny for many years. Since the mid-2010s, a succession of independent investigations have examined serious failures of care in individual trusts, notably the Morecambe Bay Investigation[21] (2015); the Ockenden Review into Shrewsbury and Telford[22] (2022); the 'Reading the signals' independent investigation into maternity and neonatal services in East Kent[23] (2022); and, most recently, the Independent Maternity Review of Nottingham University Hospitals NHS Trust (2026). While these investigations arose from local circumstances, they have highlighted common underlying issues, including not listening to women, birthing people and families, weaknesses in leadership and teamworking, failures to learn from avoidable deaths and harm, and gaps between nationally expected standards and the care delivered in practice. During the course of this Investigation, further investigations have been agreed for Leeds and Sussex.

Previous maternity reviews have also drawn attention to the cumulative impact of workforce shortages, service pressure and organisational culture on safety and patient experience. While improvements have often followed periods of external scrutiny, these changes have been difficult to sustain over time. Progress has often been achieved in the immediate aftermath of reviews, particularly under conditions of heightened scrutiny, and leadership focus with additional resources made available, however these improvements have not been consistently maintained.

Alongside these major independent investigations, maternity and neonatal services have also been the focus of attention of regulatory bodies, as well as of programmes and policy initiatives that have generated recommendations and expectations for improvement. As a result, a substantial body of recommendations and guidance has developed over time. The challenge now is not a lack of understanding of the problems, rather it is the large volume and complexity of different recommendations, standards and improvement efforts, which collectively has not translated into clear improvements.

These changes have occurred alongside a shifting policy landscape. The government's 10 Year Health Plan[24] (2025) set out its aim to implement three key strategic shifts across the health and social care system:

- From hospital-centred to community and neighbourhood-based care
- From analogue fragmented systems to more integrated digital infrastructure
- From reactive treatment of sickness to proactive prevention and intervention.

At the same time, the NHS continues to undergo significant organisational change. In March 2025, the government announced that NHSE would be integrated into the DHSC, in order to reduce unnecessary bureaucracy and release resources to support frontline delivery across England. This significant organisational reform is ongoing.

In addition to these broader societal shifts, there are aspects of maternity and neonatal services that are relatively unusual among healthcare specialties. Firstly, care is being provided to two or more people - a mother, parent, one or more babies - meaning that healthcare professionals must simultaneously act in, and balance, the best interests of the mother and the baby (or babies in multiple births), including constant risk assessment and planning for the future for both the birth and long-term health of mothers and babies. And, when serious risks occur, such as risk of death or major harm, they can happen unexpectedly and very quickly. Other notable factors that are amplified in maternity services include the high representation of women in the workforce. 99.6% of NHS midwives in England are female, compared with the wider NHS workforce where women make up 75.3% of staff.[25]

Maternity care is becoming more complex to provide. Between 2018/19 and 2024/25, there were 10% fewer births. However, births became more complex overall, with the average cost of a birth increasing by 13% after adjusting for inflation in the healthcare context.[26] The increase in complexity was largely driven by a rise in caesarean births. The proportion of births by caesarean section increased from 30% in 2018/19 to 45% in 2024/25, representing a 34% increase in the number of procedures, from 181,000 to 240,000.[27]

For many women, birthing people and their partners, pregnancy will be the most significant contact they have had with NHS services at that point, or potentially at any point, in their lives. Unlike other clinical specialties, maternity services are not primarily treating illness, although we know that illnesses can arise in the course of pregnancy and that pre-existing conditions can influence the course of a pregnancy and/or birth. Clinical negligence costs associated with maternity services have increased, especially where they relate to neonatal brain injury: the cost (including payments to be made in future financial years) of settled obstetric claims involving cerebral palsy or brain damage increased by

63% (or £599m, 2024/25 real terms) between 2016/17 and 2024/25, to £1.6bn. This is by far the largest settled claims cost of any speciality at more than four times the next highest.[28] 62% (£37.5bn) of the total clinical negligence provision (£60.0bn) relates to maternity.[29]

The picture that emerges is not one of isolated failures, but of a system under sustained and compounding pressure — pressure that has built over decades and that no single intervention has been sufficient to address.

The emotional and financial consequences of getting things wrong have grown year on year. The billions now set aside for maternity litigation are not abstract figures — they represent real harm and trauma to families, that in many cases could and should have been prevented.

There is no excuse for avoidable harm and death. Understanding the cultural and system failures as well as the pressures impacting the system is vital. If we don’t reform the system, efforts to change it will fail. These wider contextual shifts are happening within an NHS and within maternity and neonatal services where there are also deep cultural challenges including a culture which does not listen to women and birthing people.

Section 1: How does maternity and neonatal care impact families?

Care that is not compassionate and unsafe leads to avoidable harm. This affects the lives of women, birthing people, families and society as a whole. In this section, we explore the impact this has on families' experiences, outcomes and trust in services. We highlight the critical importance of listening to women and families, addressing racism, discrimination and systemic inequalities, and improving how services respond when things go wrong.

Listening to women, birthing people and families

Women and birthing people entering maternity services in England should receive a minimum standard of care that is safe, high-quality, kind and compassionate. This includes being listened to, respected and actively involved in decisions about their care.

We heard that this standard is not met consistently, demonstrated in how women's concerns were responded to, how they were spoken to, and how their choices and needs were heard and respected. When women are ignored, dismissed and disbelieved, trust is undermined and care becomes unsafe. The consequences can be devastating.

This is a central issue which has been consistently identified across previous reports and investigations. Here we set out some common experiences of failures to listen to women, birthing people and families.

When women are dismissed and ignored they feel unsupported and their care becomes unsafe

Across the maternity and neonatal pathway, many women described their concerns being minimised or dismissed by healthcare professionals, including in instances where they reported reduced baby movements or contacted maternity triage for advice. Some women were told that everything was "*fine*" or that their symptoms were "*normal*" even when they felt something was wrong. Some were advised to go home or stay at home without any further exploration of their concern.

> *"I can't really walk, and I'm in pain, and like, 'please can you help, like, can, can I see someone please?' And I had to say all this in front of other people in the waiting room, and I was like begging for care, like telling her my symptoms. It was really humiliating […] and she [healthcare professional] was like, 'Bleeding is fine in pregnancy' […] And I was like trying to get through as quickly as possible all my symptoms. And she was so aggressive, and like really, just really dismissive, and really gaslit me".*
> (Woman/birthing person)

Concerns were often attributed to women and birthing people being overcautious, worrying or lacking knowledge about pregnancy or labour, particularly for those who were younger or first-time parents. This left many doubting their own judgements or feeling like a nuisance or burden to staff, affecting their confidence to seek help and raise concerns during their pregnancy. One woman told us she thought her anxiety was used to dismiss concerns about reduced fetal movements.

> *"'You're so anxious.' I said, 'Yes, I am anxious because something's wrong – the baby's not moving.'"* (Family member)

Families talked about raising concerns, but action not being taken quickly enough, especially during labour and birth, when urgent support was requested but there were delays in assessment or intervention.

> *"It took five and a half hours to see a doctor [...] What good is a second opinion if it takes you five and a half hours to get the first? [...] Minutes can be life threatening."* (Family member)
>
> *"I was in a lot of pain, but I hadn't had any pain relief for a considerable length of time, about 10 hours. And I was told I was being a wimp – 'Most women can cope with a c-section. You're just being one of those women that can't cope with pain.'"* (Woman/birthing person)

Many felt that slow responses showed that their concerns were not truly being heard and taken seriously. In some cases, these experiences directly contributed to harm or death. For bereaved and harmed parents, their trauma was compounded by the knowledge that they had raised concerns and sought help, but they were not listened to, and action was not taken soon enough. Some described being left with lasting questions about whether their baby might have lived if they had been listened to, or if staff had acted earlier. When families are left fighting for answers, accountability and recognition of what had happened, grief is harder to process.

> *"But if they'd have done their jobs for me, my daughter would be nearly 4 years old right now. Like I shouldn't be living this life."* (Family member)

Fathers, partners and parents described similar experiences of being overlooked and dismissed when trying to support or advocate for their partner, baby or loved one. For many families, having a baby is a shared experience, but this was not always reflected in how care was delivered. In emergency situations, the lack of communication was particularly distressing, with partners left without information about what was happening. This added to their anxiety at an already difficult time.

Communication failures are experienced as a lack of compassion

Communication failures were a consistent experience across both maternity and neonatal care. Many described having to repeat sensitive and sometimes distressing information because they saw multiple staff and information was not passed on. Women described writing birth plans and ensuring that what really mattered to them, their needs and preferences for care were recorded in medical notes, but these were not always read and followed. A lack of personalised care left families feeling that no one was truly listening to them.

Women and families also described staff sometimes communicating in ways that felt abrupt or dismissive, delivering upsetting news in a blunt or impersonal manner. Some said that information was not always explained in a way they could understand. Staff used medical terminology and jargon, which they are used to using with colleagues, but families may struggle to understand. Without effective two-way communication, it can be difficult for women, birthing people and their families to process important information and ask questions, especially during stressful or emotional moments.

> *"...it was very complicated what she was telling me [...] it was very lengthy and I couldn't remember everything that she said because it was too much information"* (Family member)

Some families whose babies spent time in neonatal units described having little prior understanding of neonatal care and feeling vulnerable and anxious. This was compounded when the information they received about their baby's condition or treatment was confusing, increasing anxiety and reinforcing a sense of exclusion from their baby's care. FICare models address these concerns by ensuring that families' needs are listened to, understood and responded to.

> *"...generally I hate leaflets and reading materials, but I think it'd be good when you go into a NICU [...] Because a lot of the time, the consultants don't have time to talk to you or spend time talking with you and explaining things to you, and then when you start googling them, that's dangerous. So maybe if they could create more reading materials for you that explain a lot of the language, the machinery, the equipment, the processes, the illnesses, etc".* (Family member)
>
> *"No, I didn't really feel like the new mum. I just felt like just a bystander, I guess."* (Family member)

Action must be taken to systematically listen to the voices of women, birthing people and families

Listening to the voices of women, birthing people and families using NHS maternity and neonatal services is fundamental to safe, high-quality and compassionate care.

Listening not only shapes individual experiences of care, but it also influences how families engage with staff and the wider system. Many families enter maternity services already uncertain that their voice will be heard, based on prior experience or wider narratives they have heard from friends, family or in the media. As a result, they may feel the need to advocate strongly for themselves to ensure safe and responsive care. This reflects a powerful instinct to protect themselves and their baby, but lack of trust from the outset can mean relationships with staff feeling strained or guarded.

The responsibility to ensure they are heard cannot sit with families. The system must be designed to support staff to listen. This includes creating the conditions where staff have time, confidence and clear routes to respond to concerns and escalate to more senior staff when needed.

We must act now to put the mechanisms in place to ensure that listening to women, birthing people and families is at the heart of the maternity and neonatal system. This is a change that will have positive impacts across the healthcare system as a whole. That is why the recommendations we make are designed not as a set of isolated fixes but as a systematic response to deep and enduring cultural problems.

Racism, discrimination and inequalities

The impact on families of racism, discrimination and inequalities in the maternity and neonatal system was a significant feature of my Interim Report. What has become even clearer during the rest of the Investigation is that both interpersonal discrimination, based on a person’s identity, and structural inequality in how services are delivered, make care less safe and puts lives at risk.

In this part of the report, we shine a spotlight on the pervasive and harmful role of racism and discrimination within maternity and neonatal services, whilst recognising that the wider debates which are going on in the country about difference, identity and who belongs, will impact how what we say is understood. We are reporting on what we saw and heard supported by a body of evidence which we reference.

We also examine structural inequalities, which do not begin within maternity and neonatal services. They are reflective of social, economic and structural disadvantages that affect people throughout their lives and require action across government and society. The design and delivery of maternity and neonatal care can compound these disadvantages, resulting in differences in the quality, safety and outcomes of care experienced by families.

Racism

There are stark inequalities in maternity and neonatal outcomes

In the UK, women from ethnic minority backgrounds have persistently poorer maternity and neonatal outcomes. In 2022 and 2024, the maternal mortality rate was almost three times as high (2.7x) for Black women compared to White women, and the rate for Asian women was also comparatively higher (1.3x).[30] Babies from Black ethnic backgrounds are more than twice as likely to be stillborn compared to White babies, and neonatal death rates are higher for Black and Asian babies.[31]

These stark differences are not limited to race alone. Rates of maternal mortality were twice as high for those living in the 20% most deprived areas of England compared to those in the 20% least deprived areas between 2022 and 2024.[32] These areas also record higher rates of stillbirths or rate of deaths within the first four weeks of life. Between 2021-23, 22% of the maternal deaths were amongst those who had experienced domestic abuse before or during pregnancy, 7% had a history of childhood abuse, and 21% were known to social services. 14% were identified as having severe and multiple disadvantages, including combinations of domestic abuse, substance use, prior trauma, recent migration, asylum or refugee status, mental health needs, female genital mutilation.[33]

Racism and discrimination in healthcare operates at multiple levels. It is visible in differences in how people are treated and shows up through assumptions and bias and everyday interactions between patients and staff. Racism can also be embedded within the systems that shape care, including clinical tools, training, policies and processes. Discrimination in all its forms, whether related to race, ethnicity, religion or other aspects of identity must be recognised and addressed.

Inequality in care is not only unjust and unsafe, it is also associated with significant financial costs. It is estimated that ethnic inequalities in maternal and neonatal outcomes may cost in the region of £350 million each year in additional costs to the NHS and wider society.[34] This figure, based on direct costs and lost productivity, is likely to underestimate the full impact on women and birthing people, babies and families.[35]

The evidence presented here highlights experiences of discrimination based on a person's perceived race, ethnicity and religion. While racism and religious discrimination are distinct, they are often experienced through similar behaviours and interpersonal biases. A recent review into antisemitism and racism in the NHS noted that *"addressing antisemitism cannot happen in isolation; it is part of how we tackle racism in all forms"*.[36] We engaged with a range of stakeholders and community groups, including dedicated engagement with Muslim and Jewish families following concerns raised about their experiences in maternity and neonatal services.

Families are treated differently due to their race and ethnicity

Evidence from families highlights clear experiences of differential treatment that they linked to their race and ethnicity. This included being left waiting significantly longer, receiving slower responses or observing differences in the tone in which they were addressed and the attention given to them from staff. In some cases, accounts were grounded in direct comparison with how White patients were treated, reinforcing the view that these experiences were not random, or one-off. Other families were less certain whether treatment was intentionally racist, but nonetheless identified clear differences in care that affected their experience and sense of safety.

Families and stakeholders also reported the use of racialised assumptions, particularly towards Black and Asian women. Individuals were stereotyped as more resilient, more tolerant of pain or more likely to exaggerate symptoms. These assumptions influenced how seriously concerns were taken, and in some cases contributed to delays in recognising deterioration in symptoms, delayed clinical intervention and reduced access to pain medication.

> *"...I think for Asian women they're seen as exaggerating, and the same for Black women. They're seen as exaggerating. What ends up happening with that stereotype is that midwives and doctors underestimate how far labour has progressed. Then you start to think, well, you've got plenty of time. Everything is then rushed at the last minute, and that's when complications happen; emergency C-sections, tears, blood loss, etc. There's a consequence of stereotyping." (*Baroness Shaista Gohir, CEO, Muslim Women's Network UK)

Ethnic minority women were less likely to feel listened to. This is reflected in the data from our public Call for Evidence, where only 31% of Asian respondents and 30% of respondents from mixed ethnic groups agreed that staff listened to their concerns during labour and birth, compared with 39% of White respondents. Where families did raise concerns, they were often dismissed, not believed or feared negative consequences. These experiences can limit families' readiness to advocate for themselves and contribute to a sense of silencing.

When concerns are less likely to be raised, heard or acted upon, families feel less supported and care can be less safe. This is reflected in the Investigation's Call for Evidence survey, where only 35% of respondents from Asian ethnic groups and 37% from Black ethnic groups reported feeling safe and supported, compared with 44% of White respondents, highlighting unequal experiences of safety across groups.

Muslim and Jewish families received poor treatment from staff, which they felt was shaped by their religious affiliation. Muslim families experienced being judged, questioned and treated differently when wearing clothing during care, including being asked, *"why are you wearing this?"* during labour or appointments. Others described how their appearance led to assumptions about their ability to understand English, which in some cases, led to derogatory comments made by staff. Jewish families similarly experienced staff being unhelpful or speaking to them aggressively. In a small number of cases, families reported more explicit antisemitic attitudes, one family reported that they were told by a member of staff that *"Jewish people are sneaky"*.

As a result of these experiences, some families felt compelled to conceal their religious identity to receive better care. This included removing clothing that identified their religious identity or avoiding requests that might identify them as Muslim or Jewish. This shows how services did not make families feel welcome. Some families used doulas, to *"act as a buffer"* between them and staff and ensure better culturally competent care.

> *"They're not disclosing [...] they're hiding their identity if it's possible to do that [...] They're not, for example, ordering kosher meals because that would be a way of identifying them as being Jewish." (Jewish family panel)*

For both Muslim and Jewish families, cultural competence was not routinely built into care, resulting in care that did not fully meet their needs. Some Jewish families told us their religious identity was not acknowledged or considered at any point during their maternity and neonatal journey. Muslim families said that requests for privacy during breastfeeding and examinations, and need for care to be provided by female clinicians was not understood or met. In some cases, these requests were met with frustration and reluctance, contributing to delays in care and feelings of being dismissed.

When families experience racism, they must be supported to raise concerns easily and without fear. Evidence highlights that a lack of trust and barriers to communication can make it harder for ethnic minority families to raise concerns, reinforcing the need for accessible, trusted routes for raising concerns, with clear information, advocacy and appropriate language support. When they work well, Maternity and Neonatal Voices Partnerships (MNVPs) can help to ensure families' voices are heard to inform service improvement.[37]

NHS staff experiences of racism at work

The racism and discrimination experienced by families does not exist in isolation. The same culture and leadership that enable the negative treatment of families from ethnic minority backgrounds also shapes the experiences of staff. Ethnic minority staff described feeling excluded, undermined and treated as less knowledgeable than their White counterparts.

Many staff also feared speaking up, they felt that raising concerns about racism would result in them being treated differently by colleagues or leaders in their organisation. Some described racism as *"an accepted part of the culture*", with few consequences for bullying or discrimination and fewer opportunities open for progression.

There are clear disparities in the experience of discrimination for different minority groups. More than one in five ethnic minority staff (over 20% of respondents) reported discrimination from patients or members of the public in the previous 12 months, compared with just 5% of White staff. Similarly, double the proportion (12%) of minority ethnic staff reported experiencing discriminatory behaviour from colleagues, compared to White staff (7%). Ethnic minority staff were also less likely to feel that their trust provides equal opportunities for career progression than White staff (50% compared with 59%).[38]

Differences were also evident by religious affiliation. Staff who identified with a religion were more than twice as likely to report discrimination from patients and the public than those reporting no religion and were more likely to report discrimination from colleagues or managers. Amongst specific faith groups, 11% of Jewish and 16% of Muslim staff reported facing discriminatory behaviour from patients or the public in the last 12 months, while 14% of Jewish and 13% of Muslim staff reported having experienced discrimination from managers or colleagues at work over the last 12 months. By contrast, 5% of staff with no religious affiliation reported discrimination from patients or the public, and 6% reported discrimination from managers or colleagues.[39]

These accounts highlight organisational cultures where racism and discrimination are normalised and both staff and families feel unable to speak up. Staff must be able to raise concerns without fear of retribution.[40] Staff networks have been found to be crucial for providing peer support and surfacing racism experienced by staff and patients to senior leaders.[41][42] Staff who feel valued, supported and able to speak up are better able to identify risk, challenge poor practice and provide compassionate care.

Elements of bias, including racism, are embedded in clinical tools

Racism and resultant inequalities can also arise through the clinical tools, technologies and training that have not been designed, tested or implemented with sufficient consideration of the needs of diverse communities.[43] [44] In maternity and neonatal care, this can affect recognition of deterioration in symptoms and clinical decision making.

In the assessment of suspected newborn jaundice, standard practices, guidelines and training may be less suitable for babies with darker skin tones because they do not account for differences in skin pigmentation.[45]

Evidence also suggests that a commonly used diagnostic threshold for pre-eclampsia may fail to identify a substantially higher proportion of Black women at risk of the condition than women who do not identify as Black (41.4% compared with 22.9%).[46]

These examples show that inequalities can be embedded within clinical tools, guidance and practice, not solely through interpersonal interactions. This highlights a broader risk that healthcare systems may not work equally well for all communities when diversity is not adequately considered in their design and implementation.

This reinforces the importance of NHS Trust leaders identifying and addressing potential bias across policies, processes and clinical tools, alongside tackling racism and discrimination in interpersonal interactions.

Inequalities

Inequalities in maternity and neonatal care arise and are perpetuated through interpersonal discrimination and structural factors. Interpersonal discrimination involves treating people differently because of aspects of their identity or circumstances, such as disability, religion, language, sexual orientation, gender identity, social background or family structure. Structural inequalities are the wider conditions that shape how care is planned, delivered and experienced, including how services are organised, resourced and connected.

Although in the report we describe some inequalities through a single lens, we recognise that people’s lives do not fit neatly into separate categories. Inequalities often overlap and compound one another. Women, birthing people and families may experience racism alongside poverty, disability, migration insecurity, be victims of domestic abuse, or have experienced previous trauma. These overlapping experiences can shape how people are treated, whether they feel able to seek help or raise concerns, and how easily they can get access to and navigate care across their maternity and neonatal journey. As a result, inequalities have critical implications for the safety of maternity and neonatal care.

Interpersonal discrimination shapes everyday experiences of care

Families reported stigma and judgement being ascribed to them related to their social background and circumstances, including involvement with the criminal justice system or with social services. Families saw noticeable changes in staff behaviour once this became known, reinforcing their view that respect from staff was conditional, and not consistently afforded to all.

Families described encounters where staff appeared to apply fixed expectations about what a ‘typical’ patient or family looks like and expects, rather than adapting to the person in front of them. When people did not fit these expectations, because of disability, family structure, gender identity or other factors, they were more likely to experience care which felt inappropriate or exclusionary.

Disabled women and birthing people encountered assumptions about being unlikely to be sexually active, able to conceive, or capable of parenting. Some said that this was stated directly to them or was implicit in attitudes and behaviours such as staff directing advice about feeding or care towards partners or carers, rather than to the individual themselves.

LGBTQ+ families reported the use of heteronormative and cisnormative[iii] beliefs in care. Co-parents were often misidentified as a *“sister”* or *“friend”* and non-binary individuals faced misgendering and improper use of pronouns. Many accounts highlight the *“emotional labour”* of repeatedly explaining identities and needs, with some describing this as *“coming out again”* in clinical settings.

> *“We were asked if we were sisters at our 12-week scan and, you know, obviously you're lying there, exposed, and just feeling incredibly unsafe”*
> (Woman/birthing person)

Experiences of discrimination both within and outside of maternity and neonatal care, reduce families’ confidence in the system and constrain their willingness to ask questions, raise concerns and advocate for themselves.

NHS staff experiences of discrimination at work

Amongst NHS staff, differences in levels of reported discrimination were evident according to gender identity and sexual orientation. Staff whose gender identity differed from their sex at birth were more than twice as likely (18%) to report facing discrimination in the last 12 months from patients or the public and colleagues or managers compared to those where their gender identity is the same as the sex registered at birth (9%). Staff identifying as gay, lesbian, bisexual, or another sexual orientation were also more likely to report discrimination than those identifying as heterosexual or straight (13% vs 9%).

[iii] Definitions from Cambridge Dictionary. Heteronormative: suggesting or believing that only heterosexual relationships are normal or right and that men and women have naturally different roles. Cisnormative: believing or suggesting that cisgender people (= people whose gender matches the body they were born with) are normal or right and all other people are not.

Disparities were also found by socio-economic background, with staff from working-class backgrounds less likely to report equal opportunities for progression than those from professional or managerial backgrounds (50% compared with 55%).[47]

These experiences affect not only individual staff, but the wider culture of services. Staff cannot deliver safe care to families if they themselves do not feel safe, respected or supported. A compassionate, inclusive and psychologically safe working environment, is fundamental to provide safe, high-quality care.

Services do not meet needs of all families

Evidence highlights that service design often fails to anticipate and meet diverse needs. Disabled women and birthing people experienced a lack of anticipatory planning for their needs, including availability of suitable equipment and ward facilities. Stakeholders highlighted the importance of more inclusive services, including disability maternity passports, which help staff understand and meet an individual's support needs without requiring families to repeatedly explain them, alongside disability-aware training.

Similarly, neurodivergent women and birthing people were not routinely asked about their needs during pregnancy or care. Families explained how sensory triggers such as noise, light, smells in busy hospital environments can be overwhelming but consideration in care planning for this was not considered. Being in these environments contributed to distress and difficulty processing information, with individuals often feeling unsupported and misunderstood. Accounts highlighted the positive impact of estates with sensory rooms and quiet spaces.

LGBTQ+ families described standard maternity forms and documentation not reflecting different family structures with staff being required to adapt the forms informally, sometimes leading to incorrect or incomplete clinical information being recorded. For example, when the gestational parent is not the genetic parent, relevant medical histories may not be captured for use in care. This has implications for a family’s clinical safety and sense of belonging within services.

Language and communication barriers are a significant obstacle to the provision of safe and equitable care. Professional interpretation is not consistently available, making it harder for families to understand care and provide informed consent. In its absence, families relied on partners, relatives or translation apps, which raise concerns about accuracy, confidentiality and dignity. Deaf families reported limited accessible options, such as video calls, captions or alternative contact methods, which restricted their ability to seek advice independently. Provision of interpretation is crucial as evidence finds that women report greater confidence and a stronger sense of safety when they have access to professional interpreters.[48]

Staff echoed these concerns, highlighting gaps in training both in using interpretation tools and in delivering compassionate care through interpreters.

Structural barriers prevent access to care and support

The way services are designed and delivered can make it harder for some women, birthing people and families to access care, demonstrating how inequalities can arise.

For some families, the cost and practical challenges of attending appointments—such as travel, childcare and time off work—create significant barriers.[49] These challenges can be particularly acute for those on low incomes or living in rural areas. Some families reported missing essential appointments because they could not afford repeated travel costs or take time away from work.

A lack of coordination across maternity, neonatal, and wider health and social care services can further reduce the likelihood of women getting appropriate support. When care is not well coordinated and families are not supported to navigate complex systems, they are less likely to receive the right care at the right time. This is likely to impact those who require additional or specialist support across services, including families living in poverty, those in insecure housing, and those who are victims of violence, including FGM.

Continuity of carer approaches can support more personalised care and stronger relationships between women and healthcare professionals, which can improve engagement with services. Evidence suggests these models have particular benefit for women from ethnic minority backgrounds and those experiencing social disadvantage, with potential to reduce inequalities in outcomes.[50] [51] [52]

Women and birthing people from deprived areas, ethnic minority communities, those whose first language is not English and those experiencing unemployment are more likely to experience later referral and longer waits following referral[53] to antenatal care. Timely access to antenatal care is important for improving maternity and neonatal outcomes. Community-based approaches,[54] [55] [56] including maternity navigators, peer support and partnerships with voluntary organisations have been found to improve engagement with maternity services and support access to antenatal care, particularly among ethnic minority groups, recent migrants and those living in deprived communities.[57] [58] [59] Interpreter-supported antenatal education has also been shown to improve knowledge, confidence and engagement with maternity services among parents from ethnic minority backgrounds.[60]

Data gaps limit visibility of inequality and slow action

Stakeholders describe deficits in data as a driver of persistent inequalities in maternity and neonatal care. High-quality data are essential to help identify inequalities, inform action, monitoring whether interventions are working.

Variation in how ethnicity data are collected and recorded across trusts, alongside the use of broad ethnic categories can mask important differences in outcomes. More granular data is needed to better identify and address inequalities. Gaps were also identified in the collection of data on other groups including, LGBTQ+ families and families with disabilities. The lack of data limits the visibility of the maternity experiences and outcomes of particular groups and reduces the likelihood that appropriate action is taken or progress monitored.

In addition, experiences of care, which are impacted by discrimination, communication challenges, lack of trust and lack of cultural competence are not captured when data collection focuses solely on clinical outcomes. They NHS needs to routinely capture both outcomes and experiences to fully understand inequalities.

However, we recognise that whilst it should be a priority to collect granular data, families may be reluctant to disclose ethnicity data driven by concerns about racism, discrimination and how data are used. This is compounded by limited staff confidence in explaining why data are collected and how they are used to inform service improvement.

A co-ordinated national effort is required to address racism, discrimination and inequality in maternity and neonatal care safety

Tackling racism, discrimination and inequalities is fundamental to improving the safety and quality of maternity and neonatal care. Without action, these issues will continue to contribute to unequal outcomes and avoidable harm.

There is encouraging work to tackle racism across the NHS, including the Perinatal Equity and Anti-Discrimination Programme, led by the independent NHS Race and Health Observatory. However, other initiatives are often developed locally without consistent evaluation, shared learning or the ability to scale and spread good practice. Many initiatives are small-scale, time-limited and dependent on local leadership and funding. They do not yet form part of a coordinated, national approach to reducing inequalities across maternity and neonatal services.

Addressing these challenges requires sustained action across trust and national leadership, culture, workforce, data, service design, communication, interpretation, trauma informed care and community partnership. A safer maternity and neonatal system to address the needs of those who face the poorest outcomes. When care is shaped around those who face the greatest risks and barriers, it leads to safer, higher-quality care for all women, birthing people and families.

Actions must address systemic failure and be grounded in evidence. Services need to make better use of data to identify where inequalities exist, target action, and monitor whether change is making a difference. The lived experiences of families and staff should be included to shape how services are designed, delivered and can be improved, with communities having meaningful influence in design and decision making. Consistent national oversight is also required to increase transparency, strengthen oversight and enable accountability and shared learning across the maternity and neonatal system.

When things go wrong, families do not get the answers they deserve

The final impact on families we explore in this section is the response they receive when something goes wrong. From the beginning of this Investigation, we have heard about the lifelong and devastating consequences for women, babies and families when something goes wrong during maternity and neonatal care. This is exacerbated when women and families are met with defensiveness and failures are minimised, obscured or left unacknowledged. Families expect a sincere apology and clear explanation of what happened to be provided. For many of the families we met, they received neither apology nor explanation.

The harm or death of a baby or mother is devastating. It is particularly important that families are given the time and space they need to have their questions answered and are given feedback. These experiences result in long-term psychological distress, often with unsatisfactory signposting to bereavement, trauma and psychological support services, with many women and their families blaming themselves for what has happened.

The system of investigations in maternity and neonatal care is almost impenetrable in its complexity. There are four different types of investigation that may review a family's care, each with its own purpose, criteria and processes. This fragmented landscape is confusing and burdensome for families already searching for answers, and asking a grieving family to navigate it is, frankly, beyond comprehension. In addition to the complexity, we repeatedly heard how families felt excluded and ignored during investigations, with their accounts sometimes removed from findings and, in some cases, findings not even being shared. Some families described instances where the loss and harm they had experienced was not even the subject of an investigation and instead spoken of as an unfortunate event. The impact on families, and the compassion they are owed, have too often been lost, along with sight of why these investigations exist in the first place.

Families who have tried to get answers when harm has occurred faced common issues, leaving them bewildered and angry. They reported:

- A sense that internal investigation teams were 'marking their own homework'
- Investigations contradicting the original account of what had happened and/or downplaying or reframing failings
- NHS trust leadership prioritising reputational protection over learning
- Key clinical staff not making themselves available for meetings
- Long delays in communication
- Generic apology letters
- Missing or altered records

- Not being warned before receiving upsetting and sensitive information about their baby's death via email or post
- Limited feedback on actions taken.

For some women and families, the only way they felt they could get answers was to pursue legal routes.

> *"Once your baby suffers critical injuries during her birth, there isn't really any form of support you can be offered that feels worthwhile. Except one thing and one thing only: the truth of what happened and why it happened. And that's something we have yet to been given."* (Family member)

We found that, despite numerous types of investigations, these investigations were failing to drive improvements and make meaningful differences to the safety and quality of care delivered to women, birthing people and babies. We heard about the inconsistent quality of investigations, and that there were no consistently robust systems for ensuring that the outcomes of these investigations were routinely integrated into clinical or operational practice. We found a system that appears to be unable to learn from its mistakes. Families expressed their deep pain knowing that their loss might have been prevented if lessons had been learned sooner.

There are four main types of investigation

The four different types of investigation that may be undertaken if a family has suffered harm or loss are:

1. **NHS Trust Patient Safety Incident Response Framework (PSIRF):** In 2022, NHSE published the new PSIRF[61] which set out how trusts should respond to patient safety events resulting in harm in healthcare. When an incident resulting in harm occurs to women, birthing people or babies, the trust will consider how best to respond and learn from the incident. If the incident highlights previously unknown safety issues in the care delivered, an investigation may take place. If the incident is not judged to provide sufficient learning potential in terms of identifying new previously unknown safety issues, it is unlikely to result in an investigation. This means that where harm has occurred there may not be an investigation. The PSIRF allows for Trusts to make the decisions regarding what is investigated. We have repeatedly heard from families that they are given an account of what has happened by the Trust that does not accurately identify what has happened and does not properly identify what went wrong. PSIRF will not provide a challenge to this situation.
2. **The Perinatal Mortality Review Tool (PMRT):** The PMRT[62] is a structured multidisciplinary review process that was introduced in 2018. This is designed to support

the clinical review of baby deaths from 22 weeks' gestation onwards, including late miscarriages, stillbirths and neonatal deaths. For about 90% of families, the PMRT review process is likely to be the only hospital review of their baby's death that will take place. There must be a quarterly PMRT report submitted to each NHS trust board. The evidence we have collected has called into question the independence of PMRT processes and its ability to drive change. We saw through our review of Trust documentation that there was limited review of trends which reduces the ability of the Trust to use PMRT to bring about change.

3. **Maternity and Newborn Safety Investigation (MNSI):** MNSI investigations are launched in certain circumstances, including when a mother or birthing person dies, and cases involving babies born at term (37 weeks or later) following labour where the outcome is: an intrapartum stillbirth; an early neonatal death (within the first week of life); or a potential severe brain injury following birth. MNSI investigations are expected to be completed within six months from the point of referral. The majority of families we spoke with valued the independence of MNSI investigations and said that it was often only through an MNSI investigation that they found out what happened.
4. **Coronial Reviews:** In England, a coronial review is permissible where a baby has shown signs of life after being born or where there is dispute about whether they did so. A coronial review is not available in the case of stillbirths. This is explored further below.

Women and families told us of cases where harm had occurred and no investigation or review was undertaken because staff judged there to be no errors in the care provided. The harm was deemed an unavoidable complication of pregnancy, labour or birth: *"just one of those things"* that required no detailed discussion. We also heard that even if families wanted an independent investigation, if they did not come within the criteria for MNSI, this was not available to them.

It is also possible that a family may be involved in multiple investigations, requiring them to retell and relive their experiences over and over again, further reinforcing trauma and distress. We heard how families' search for answers after a loss or harm has occurred can be protracted, with trusts being defensive rather than open.

> *"We spent nearly two years emailing […] the trust consistently denied that it had done anything wrong."* (Family member)
>
> *"Trusts still have a tendency to throw up a brick wall […] close down the shutters."* (Donna Ockenden, Chair of the Independent Reviews of Shrewsbury and Telford Hospital NHS Trust and Nottingham University Hospitals NHS Trust)

We recognise that no system, however well-designed, can entirely eliminate the risk of something going wrong and harm or loss occurring and that not all loss in maternity and neonatal care arises from a mistake in the delivery of care. However, all harm and loss, whether or not it arises from an error or a care delivery issue, is devastating for families. Families need a full explanation of what has happened to them and why the loss and/or harm has occurred. They also need to be able to trust the account given to them. At present there are many instances where this is not happening and causes further harm and distress to the families involved.

Investigations should apply a trauma-informed approach

Published reports have previously identified a variation in maternity and neonatal investigation quality, including the ability to apply a trauma-informed approach.[63] The PSIRF requires those leading investigations and engagement with patients and families to be appropriately trained. It also states that there should be dedicated time and resource available for this. A Health Services Safety Investigations Body (HSSIB) report published in 2025 identified that staff did not have the necessary training, mentoring, or support to enable them to develop the expertise needed for safety investigations.[64] Without this, the report concluded it was unreasonable to expect staff to be skilled safety investigators.

> *"…[women and families] don't feel those reports are done with them, they feel they're done to them".* (The Rt Hon Jeremy Hunt MP, former Secretary of State for Health and Social Care)
>
> *"…investigation capability is very limited […] how do we support these investigators to improve to really, kind of, work with families and those affected? But also, importantly, to really lead to the changes and to the recommendations and changes locally that are going to deliver sustainable change."* (Dr Rosie Benneyworth, Interim Chief Executive, Health Services Safety Investigations Body)

There is a clear need to professionalise the role of healthcare investigator supported by clear competencies and consistent standards. The need for professional investigators is already recognised in other safety-critical industries such as aviation, maritime and rail and it should be the same for healthcare. In 2026 the first competency framework was published for healthcare safety investigators.[65] The professionalisation of healthcare investigation will improve the skills and expertise that healthcare investigators and improve the quality of investigations. The improvement in quality of healthcare investigations will increase the confidence and trust that families have in these investigations.

Investigations should have a culture of learning, not blame

There are lost opportunities for proactive improvement that could help prevent tragic events being repeated in other trusts. Maternity and neonatal services have become increasingly visible and prioritised at trust board level. However, we saw from our reviews of trust documentation that boards are not always sufficiently curious about the information they receive on maternity and neonatal investigations. In some cases, quarterly PMRT reports were accepted by trust boards without challenge, even when they showed repeated, similar errors of the same kind. We also noted that there was minimal evidence of trusts using these reports to inform longer-term trend analysis and planning of services.

> *"…we are aware that historically whilst some trusts have agreed the safety recommendations with us, they have not progressed them internally."* (Sandy Lewis, Director, Maternity and Newborn Safety Investigations)
>
> *"…in our ICB and system […] it was confusing about where we were, what we were doing […] having come from providers […] and overseeing the improvement plan, I felt it was all a bit, well, what's my role in it".* (Integrated Care Board member)

Poor quality investigations also negatively impact staff wellbeing and trust.

> *"[There is] a very profound lack of confidence that if you make an honest human mistake […] you'll be treated fairly […] you need […] an environment where a midwife can say, 'I may have got that wrong' […] and be confident that that will be treated as a brave thing to say."* (The Rt Hon Jeremy Hunt MP, former Secretary of State for Health and Social Care)

There is a lack of accountability across the system

A culture can be open and psychologically safe, encouraging honesty and learning, while still maintaining responsibility and accountability. Accountability is about being answerable for decisions made and actions taken. It is key to ensuring consistently safe systems and processes are in place when delivering services in maternity and neonatal care.

The lack of system and personal accountability when things go wrong is a source of deep frustration and anger to families. Families said that they experienced a lack of accountability right across the system when things had gone wrong.

> *"I needed them to admit they had caused his death. In my eyes if they're not going to admit to what they've done, how can they learn from that? How can they avoid it happening again if they don't believe they did anything or they won't admit to what they've done?"* (Family member)

> *"…there is insufficient local accountability unless the eyes of the world are upon organisations."* (Donna Ockenden, Chair of the Independent Reviews of Shrewsbury and Telford Hospital NHS Trust and Nottingham University Hospitals NHS Trust)

Under the PSIRF, accountability primarily sits with trusts.[66] It is incumbent on trust leaders to demonstrate that:

- Investigations are credible.
- Findings are acted upon.
- Safety actions are implemented and monitored.
- Families are meaningfully engaged and involved.
- Organisational learning leads to measurable improvement.[67]

The lack of robust systems for acting on investigation findings with the compassionate involvement of families has resulted in a system that repeats the same failures.

> *"This need from bereaved families for independent case reviews will remain until maternity services respond in an appropriate way when harm occurs."* (Professor Donald Peebles, National Clinical Director for Maternity)

The quality, transparency, oversight, and accountability of investigations must be improved, and learning must be acted on

When death or harm occurs families should be offered a full explanation of what happened. Greater clarity regarding how all types of investigation should be delivered is required, along with an improvement in investigation expertise.

When things go wrong, the consequences can be lifelong and devastating. Therefore, women, birthing people, and families should be supported in identifying, understanding, and accessing appropriate psychological support services. To improve families' experiences of investigations, the investigation pathways need to be clearly communicated to them and the quality of investigations significantly improved. The provision of specialist investigation expertise, and support for those staff undertaking investigations, is variable across trusts. Staff should not lack access to training that develops skills in trauma-informed approaches.

Furthermore, oversight of local investigations must be strengthened to provide the required scrutiny. Independent safety investigation organisations should combine to ensure that this expertise is offered to all trusts.

Coronial review

One route available to families to understand what has happened to their baby is coronial review. The Terms of Reference for the Investigation asked us to particularly examine the role of Coroners in the investigation of stillbirths.

In England, a coronial review is only permissible where a baby has shown signs of life after being born, or where there is dispute about whether they did so. A coronial review is not available for babies who are stillborn, because a coroner does not have jurisdiction when a baby is not considered to have lived independently of the mother.[iv]

- A coroner will consider if the duty to investigate the death, contained in Section 1 of the Coroners and Justice Act 2009,[68] applies (duty to investigate the death if the coroner has reason to suspect that the baby died a violent or unnatural death, where the cause of death is unknown, or where the baby died while in custody or state detention).
- A coroner may decide to investigate and, if appropriate, can order a post-mortem examination to medically determine the cause of the baby's death. The investigation can be concluded if a natural cause of death has become clear and the coroner thinks it is not necessary to continue the investigation.
- If the post-mortem does not clarify a natural cause of death, the coroner can open a full investigation culminating in a court hearing, known as an inquest.

Coronial reviews usually cannot begin until other investigations have concluded and, where a review leads to a postmortem or inquest, families may wait years for a conclusion. These delays can prolong families' distress, leave them without a clear understanding of what happened, and make accountability feel more remote.

However, some families described the benefits they had gained from a coronial review.

> *"At the inquest the Trust then gave answers or gave more detail and perhaps clearer answers that led the narrative that they gave to be more*

[iv] This contrasts with the law in Northern Ireland, where coroners are allowed to investigate stillbirths in cases where the baby was capable of being born alive. We also considered the Republic of Ireland, where coroners have the power to investigate stillbirths, although this power is not used in every case.

> *representative of our experience as we remembered it."* (Family member)

When the Investigation's Terms of Reference were developed, we were contacted by families who wanted us to investigate whether coroners should have a role in investigating stillbirths. The call for us to consider this issue was in part because the government had yet to respond to its 2019 consultation, which sought views on extending coronial jurisdiction to stillbirths in England and Wales. That consultation focused only on babies who are stillborn at 37 weeks gestation or later. While our Terms of Reference stated 37 weeks, following family feedback, we agreed that it was important to look at babies stillborn from 24 weeks gestation, as many of the same questions about coronial involvement apply.

There are a range of views on extending coronial review to stillbirths

Most families we spoke to regarded coronial reviews as a way to find answers that are reliable and dependable, in contrast to their experience of NHS reviews and investigations. They recounted traumatic stillbirth experiences and the absence of any independent investigation beyond a hospital review.

> *"It shouldn't have happened. A coroner should have been involved. [name]'s death was negligent of the highest form and yet I had to -- well, we had to fight, me and my partner had to fight to get those answers and to get an independent investigation."* (Family member)

Some families expressed that the inconsistency in treating stillbirths differently from other deaths implied that their babies were not regarded as important or that their babies' deaths did not deserve independent investigation.

> *"Any other death, whether it's questions about cause, care or preventability, can be referred to a coroner. The only implication that can reasonably be drawn from stillbirths being excluded is that those children are not treated as people and their deaths do not warrant independent scrutiny."* (Family member)

Another family said that a difference of just one minute meant their baby was born alive and therefore triggered coronial involvement. They contrasted this with cases where babies are registered as stillborn.

There were differing views among families as to whether, if stillbirths were brought within the coronial system, this should be subject to parental consent. Some families took the view that coronial reviews of stillbirths should not be contingent on parental consent, because stillbirth should not be treated differently from other deaths which require coronial scrutiny. However, others took the view that there may be reasons why families would not want coronial involvement.

> *"Some parents won't want a postmortem for their own personal reasons or for cultural reasons or religious reasons. They'll just want to carry on and do what it is that's right for them. As soon as we give coronial jurisdiction over stillbirths, we're taking that choice away from families. So some families will want it and other families will not."* (Family member)

We spoke to some families who have been through the coronial process following a neonatal death. Some reported finding the process adversarial and difficult, causing prolonged mental distress and trauma. There was also some distrust in how trusts engaged with coronial reviews, alongside concern that trusts typically had access to more legal support than families.

We considered the practical implications of extending coronial review to stillbirths

If legislation is to be introduced to allow coronial review of stillbirths, we heard about the need to consider any consequential changes or implications, for example in relation to rights of the fetus. In addition, coroners would need to work in conjunction with medical examiners (senior medical doctors who provide independent scrutiny of the causes of deaths not investigated by coroners) who would require training to examine stillbirths.

> *"The majority of medical examiners, who can come from any speciality or general practice, is that the majority work with adults, and therefore often feel less confident about dealing with paediatric deaths, and stillbirths will be no exception."* (Royal College of Pathologists member)

There was also concern raised that coronial services and paediatric and perinatal pathology capacity are already under significant pressure, which would be exacerbated by adding stillbirth investigations. However, enabling coroners to review stillbirths would not necessarily require all stillbirths to be investigated (under the current legislation, Section 1 of the Coroners and Justice Act 2009 would need to apply).[69] A former National Medical Examiner told us that, if stillbirth cases followed a similar pattern to neonatal deaths and medical examiners were involved, there was unlikely to be a significant increase in cases.

The Interim National Medical Examiner, who oversees the medical examiner system in England, felt that coronial review processes can create fear and defensiveness among healthcare staff rather than supporting openness and learning, and it is unclear whether NHS trusts consistently act on learning from coronial reviews and inquests. For families, visible learning and change were central to accountability. Without evidence that lessons had been acted on, trust and confidence are further eroded.

The government must publish the response to the consultation which was held in 2019 seeking views on introducing coronial investigations of stillbirth cases in England and Wales

All women, birthing people and families who experience a stillbirth should have the opportunity to have their questions answered so that they understand what happened and why. This might be through a coronial review or other appropriate method.

Wherever possible, when there is more than one process ongoing (for example, when there is a local trust investigation and an inquest) families should not have to repeatedly retell their experience. Processes should be aligned, with information shared appropriately, to ensure that families only have to recount their experience once.

The government should fulfil its legal obligation and publish its response to the 2019 consultation on extending coronial jurisdiction to stillbirths without further delay, taking account of the additional evidence provided in this report.

Compensation processes can exacerbate trauma

We have an adversarial legal system, which is complex to navigate, particularly for families who are experiencing the loss or harm of a baby or loved one. For a family to succeed in a claim for compensation, they must establish negligence, including breach of duty, causation, and recoverable loss. This is distinct from the concept of ‘avoidable harm’ often used in the context of reviews and inquiries. An incident may be found to involve avoidable harm, but that does not necessarily mean that the legal test for negligence is met.

The term negligence is not formally defined but has been established as a failure to exercise reasonable care, generally because of an act or omission that does not meet the standard of care expected, and results in injury or loss.

The current framework inevitably leads NHS Resolution,[v] which represents NHS providers in the claims process, to take a defensive approach. A finding in favour of a claimant depends on establishing negligence which is a serious and significant judgment for any individual. This framework can create incentives for clinicians and managers to deny problems, emphasise that outcomes were unavoidable, and challenge the accounts of claimants, even where other processes including inquests have identified failings.

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[v] NHS Resolution manages clinical negligence claims on behalf of NHS organisations and administers relevant indemnity schemes. It is not a regulator, commissioner, or provider of maternity and neonatal services. Its safety and learning role is to use insights from claims and to support learning and inform wider improvement activity.

The changes in funding arrangements over the past 20 years have changed the number and type of claims being made for clinical negligence. The introduction of Conditional Fee Agreements (CFA, also known as no-win-no-fee) in the mid-1990s, and the restrictions on Legal Aid (most significantly in the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012)[70] have changed the profile and number of claims being made. Legal Aid cases had already begun to drop prior to the LASPO Act being introduced, and the number of CFA cases had risen significantly from 2006 until 2013 when they plateaued. Although obstetrics claims only account for approximately 11% of clinical negligence claims, they accounted for 53% of the value of all notified claims in 2024/25.[71]

Families described the claims process as difficult and distressing

We spoke to families who had sought compensation following the stillbirth or neonatal death of their baby. Some families told us they only took the route of seeking compensation when trusts failed to give answers.

> *"I think we potentially would have never gone down the route of litigation [claiming] had the Trust been honest [...] Months and months that hospital Trust had to form any kind of open and honesty before we went down the litigation [claiming] route."* (Family member)
>
> *"So that's why we took litigation [made a claim] because we had no independent investigation. We had no option. If we wanted to know why our son died independently, without being investigated by the hospital that caused his death, then litigation [claiming] was the only route."* (Family member)

Families described the process of seeking compensation as *"brutal"* and *"cruel"*. They felt the system was weighted against them, with many families struggling to find solicitors who would take their case while the trust was able to employ senior lawyers at public expense.

> *"The only way you can have any representation at an inquest is if you pay for it, which most families can't afford, or if you plan to sue the NHS. And most families at that stage don't know they've been harmed, they don't understand what's happened to them, so they're not thinking about that. So then, they go into these inquests with no representation, and you know [...] [law firm] rock up with a KC."* (Family member)

Bereavement and harm cause significant emotional as well as financial costs for families and wider society, particularly in cases where women, birthing people, or their partners are unable to work, require long periods away from work, or require long term support caused by bereavement or harm during pregnancy or labour. Similarly, a baby who has experienced life-changing harm may need a high level of NHS and social care support throughout their lifetime. When harm occurs during or after pregnancy, it can lead to very high financial costs later on. One family described being unable to continue seeking compensation without further legal aid, *"they wanted £800 more. I couldn't do it, so they closed the case"*.

> *"Why are they fighting it? There's no need for them to fight it other than to cause more difficulty for the family, which is cruel. The only thing I conclude is that it's to do with money. That's a disgusting way to treat people that you've harmed."* (Family member)

Some families were also critical of the fact that a partner who witnessed baby loss can no longer claim for compensation, following a Supreme Court ruling in 2024. [72]

> *"A dad invited into an operating theatre, put in scrubs, is classed as a bystander in the eyes of the law, and he is no longer entitled to be compensated for any of the harm that he suffered, for anything that he'd witnessed, and that is the biggest injustice."* (Family member)

Alternative approaches aim to lessen the impact of the adversarial process

Other countries have compensation schemes that do not depend on adversarial legal systems, including Sweden, New Zealand, and Denmark, and some have compensation schemes that offer a variety of routes for resolution which families can choose from. In some countries an independent case review is included as part of the process to provide answers to families.

Some families we spoke to felt a no-fault system would make it harder to get answers. One told us that their case had helped them understand so much more about what had happened to their baby and they were concerned that a no-fault scheme would be a way for a trust to avoid scrutiny and a true understanding of what had gone wrong would never be available.

NHS Resolution has introduced alternative dispute resolution processes aimed at resolving claims without the need for court proceedings. It has also introduced the Early Notification Scheme (ENS) for the most severe maternity brain injury cases, which enables earlier investigation of eligible cases where families agree to participate. Taken together, these approaches are intended to reduce the impact of the adversarial process and support earlier learning. The ENS process has improved the very long lag times between the incident and the resolution of a claim.

> *"So coming back to the intentions of the early notification scheme, you're right, it was to target a specific subset of brain injury cases. Those which are, well, historically had very long time lags from the inception, well, from the incident to inception of the claim to the eventual resolution of that claim, which historically was around 11 years [...] I mean, clearly we can always improve. We can always do more. And our experience of things like the EN scheme grows daily. Because this is new, innovative. To our knowledge, it's not being done anywhere else in the world to this scale."* (NHS Resolution)

However, we were also told that it can still take up to two years before families find out whether there is going to be an admission of liability. The Society of Clinical Injury Lawyers (SCIL), alongside others, told us:

> *"So, often with the ENS system [...] for that investigation process to take place, we're often seeing that it can be 18 months to two years before the families will even hear whether there is going to be an admission. If there isn't, they've got to start the process. After that time, two years trying to navigate your catastrophically damaged child within statutory services is incredibly difficult."* (Society of Clinical Injury Lawyers)

We note that families going through the new process will not have experienced the alternative. We have been told by NHS Resolution that the timescales within ENS are significantly shorter compared with the pre-existing process.

The benefits and drawbacks of an alternative compensation system for adverse events in maternity and neonatal services should be considered

We have heard of the damaging impact of the adversarial nature of the compensation system. DHSC/NHSE must commission and publish a report to examine the benefits and drawbacks of an alternative compensation system for adverse events in maternity and neonatal services. This alternative system would aim to promote less adversarial relations between trusts and harmed and/or bereaved families and promote better learning from adverse events.

Since July 2025, David Lock KC, a senior independent lawyer has been advising the government on the rising legal costs of clinical negligence and how to improve patients' experiences of making claims. If this does not include the review described above, we recommend that it is incorporated and that recommendations following the review are implemented.

Section 2: How the system delivers maternity and neonatal care

We move now from the personal impacts for families of not listening to women, racism and inequality and what happens when things go wrong, to looking at the maternal and neonatal system itself. We start by setting out our findings about how the system is currently operating across the maternity and neonatal pathway. We then discuss the underpinning elements of the system which are critical to deliver safe and compassionate care:

- Governance, oversight and accountability
- Leadership, teamworking and culture
- Workforce pressures
- Estates and IT systems.

We investigated the design of maternity and neonatal services and clinical pathways, examining what is experienced by women, babies and families today, and considered how care should be organised to provide joined-up, safe and personalised support for women, babies and families throughout their entire care journey.

Early pregnancy care and advice, antenatal appointments, triage, availability of birth choices, ward designs, the number of operating theatres and staffing models all experience pressures, as the demands placed on maternal and neonatal services have grown. The consequence is a service that is, in many respects, being asked to meet twenty-first century need with a twentieth century design. An urgent rethink is required.

What we found

Antenatal care does not fit required needs

The overall number of outpatient appointments in maternity services have increased between 18/19 and 23/24, as well as appointments per birth. The structure of antenatal care — time allocated, and content of antenatal education — has not been meaningfully redesigned to reflect the increasing complexity of care during pregnancy and growing information needs associated with that. Staff told us that there is rarely enough time within appointments to have the detailed, sensitive conversations needed to help women and birthing people understand their individual risk, how to manage it and how it might change.

“People sit at home Googling, don't get the right information and actually they just need to have some sessions sitting down with the people

> *that do know in a calm place during their pregnancy to be told what can happen, what the implications are."* (Family member)

Access to antenatal education is variable across England, with provision largely determined locally. Families continue to report limited availability and reliance on paid alternatives, further entrenching inequalities through the exclusion of women who are unable to pay for these classes. Antenatal content provided by private and third sector providers is independently determined and may not provide sufficient information to families about the potential need for medical interventions. Current provision does not meet the need of modern maternity services.

Women and birthing people can also experience difficulties at the earliest stage of pregnancy, before maternity provided antenatal care has started. GPs play a crucial role, yet both families and midwives report mixed experiences, with some women facing challenges getting routine care or prescriptions via GP services.

Continuity of midwife carer results in better experiences for women, but is not routinely offered

One of the most important aspects raised by women was whether they saw the same midwife, or small group of midwives, throughout their pregnancy — known as 'continuity of carer'.

> *"In my second pregnancy, I had one midwife, so supportive, the whole way through, which completely changed it [from] my first birth where I had a different midwife every appointment. So, we had to start all over again, you've got about a million different points of view."*
> (Woman/birthing person)

Women who experienced continuity of carer described feeling listened to, supported emotionally and safer. Without it, they had to constantly repeat their care history, particularly hard for those with complex histories, previous trauma, women who had undergone fertility treatment, or women with a disability.

> *"I didn't ever have the same midwife and due to complications [...] I constantly would have to explain my pregnancy over and over again."*
> (Woman/birthing person)

National policy[73] is for every pregnant woman or birthing person to have a named midwife. There is evidence of the benefits of a woman seeing the same midwife, or small team of midwives, throughout pregnancy, labour, and the postnatal period. This evidence is particularly strong for women who are socially vulnerable, where trust and consistent relationships matter most.[74] Evidence also points to cost savings, particularly during the antenatal period,[75] and to reduced stillbirth rates for Black women who receive continuity of midwife care. NHSE's Core20PLUS5 programme[76] continues to identify continuity of care for women from Black, Asian and minority ethnic communities, and from the most deprived areas, as a priority.

Despite the clear evidence, and a policy to implement continuity of midwife care across the full maternity pathway from 2016,[77] this has been found to be challenging to deliver at scale because of staffing constraints and logistical challenges. We note that the National Institute for Health and Care Research (NIHR)[78] funded a recent study which drew similar conclusions. Many of the trusts we visited said they wanted to offer this model, and we saw small scale examples of it working well across the full maternity journey during site visits. Continuity of carer is not a luxury — it is a clinical safety mechanism, and service design must reflect that.

> *"We know that continuity of care matters, or continuity, you know, either from an individual or from a team, you know, it could be a team of three or four midwives. Why? Why isn't it there?"* (Dr Penny Dash, Chair, NHS England)

Maternity Triage is a critical safety gap in trusts' service design

Maternity triage has become the Accident and Emergency service for pregnancy related concerns. All concerns, ranging from the straightforward to the most serious, often first present here. It is where time-sensitive clinical decisions are made and where inappropriate decisions or delays can have serious and irreversible consequences. It is, in every meaningful sense, a safety-critical environment.

Maternity triage often begins over the telephone, when women make contact with concerns about reduced baby movements, abdominal pain, bleeding, headaches, sickness or signs of labour. We heard repeatedly about the consequences of triage not functioning as it should.

> *"They said there's not enough room in the triage room, so we had to go and wait in the corridor. And we were there from, well, we got there at 10.00 pm, and we were put in a [triage] bed at 2.10 am [...] she was concerned with the baby's heartbeat, so I was put on a CTG, and then just left [...] we were told that a clinician or a consultant or someone would come and have a look, but then we were -- we were just left [...] And then I could see it [the baby's heartbeat] going down, and down, and down, and then it was like going down below 90, and we were just left*

> *[...] They said she wasn't delivered [...] when she should have been."*
> (Woman/birthing person)

The evidence we gathered, including during site visits, was deeply concerning. Despite national guidance[79] setting out minimum staffing levels by unit size and the physical infrastructure required, including that triage cannot safely be staffed from labour ward numbers alone at peak times, maternity triage is frequently operating without appropriate numbers or seniority of decision makers, or the physical space needed to deliver safe care. Some women who attended after a phone call with urgent concerns told us that they waited hours without medical assessment.

> *"In the afternoon, again, the expectation was that we would cover the wards. So, from one o'clock onwards, that's when [...] triage start getting busy as well. We wouldn't have much oversight of what was going on on labour ward because we would be pulled into all of these different areas."* (Staff member)

In some units, the triage area could not accommodate the volume of women and birthing people attending or waiting to be seen, did not allow for continuous monitoring, and was not positioned in a way that supported rapid escalation when needed.

Demand for triage is at present unpredictable, with sudden surges in activity that require rapid access to experienced clinical decision-makers. Despite this, triage has not consistently been prioritised or resourced and competes with other acute clinical areas such as the labour ward or operating theatres for the same senior staff and resources. One clinician on the rota is not physically able to be in two places at the same time, and staff have to constantly juggle competing priorities, triaging cases on deemed urgency and need.

> *"So we were covering antenatal ward rounds, Day Assessment Unit, triage and supervising on labour ward. It was exhausting and impossible."*
> (Staff member)

These are not isolated failures. CQC's national review of maternity services[80] found triage to be one of the most consistently concerning areas across England, with delays in assessment and timely action identified as a recurring safety issue in unit after unit.

Maternity triage plays a critical role in the assessment and management of women requiring urgent maternity care. However, our review found considerable variation in the design, resourcing, and staffing of services. In many cases, triage facilities had not been planned or developed in a way that reflected the volume, complexity, or acuity of demand.

Addressing these issues will require maternity triage to be recognised and planned as an urgent care service, supported by appropriate infrastructure, workforce planning, staffing standards, and performance measures. Without a more consistent approach, variation in the quality and capacity of triage services is likely to persist, with implications for service delivery, patient experience, and clinical outcomes.

Risk assessment should be a critical part of personalised care

There are significant concerns about how risk assessment is currently working in maternity care. National guidance[81] requires that women are categorised as 'high risk' or 'low risk' at their first antenatal appointment to determine if a referral to obstetric care is required. However, risk during pregnancy is not fixed — it changes, sometimes rapidly.

There is rarely enough time within appointments to have the detailed, sensitive conversations needed to genuinely discuss risk and how it may change. These conversations are not optional; they are a clinical and legal obligation.

> *"I think this kind of false dichotomy between low risk, where we have midwifery-led pathways, and high risk, where we have obstetric-led pathways, I think it's actually outdated and quite damaging. I think actually what we need is that it is recognising that women are pregnant with complexity, some of which develop through pregnancy and you need a continuum".* (National body representative)

Midwives told us they were left 'holding' risk alone, without sufficient guidance, support, or documented clarity about what was expected of them. This causes real anxiety and has direct implications for safety. Staff need clearer frameworks for conversations, dedicated time to have them, and better systems for documenting and sharing the outcomes.

> *"Even somebody with the same medical condition will not have the same schedule of antenatal care, particularly when it comes to consultant-led appointments in one hospital compared to the one down the road, really. I think that's something which having a kind of framework or sort of baseline expectation for that may be quite a sort of helpful point".* (National body representative)

Birthing outside of guidance is an emerging challenge

While acknowledging that maternity services should respect women's autonomy to choose how they birth, birthing outside of clinical guidance - whether by declining recommended interventions, not coming into hospital when advised to, or giving birth without any assistance from maternity staff (freebirth) - is a growing challenge for NHS maternity services across England. It is an area where there is insufficient data and we suggest further steps should be taken to measure the numbers via birth registrations.

This is also a situation for which national policy and guidance is lacking, leaving staff to make difficult decisions. Whilst there is Royal College of Midwives (RCM) guidance[82] on care for women and birthing people giving birth outside guidance, published in 2022, this has not been translated into national policy or guidance. This must be urgently addressed. Community midwives' professional code of practice and duty of care means they must attend people who choose to give birth outside of guidance, but they do so without any policy and legal clarity and too frequently without senior or meaningful support. Midwives described times where they were left traumatised by events and fearful of future similar situations. In addition to their psychological wellbeing, midwives also face potential professional consequences for responding to situations where there is no policy or guidance to enable consistent practice.

> *"Care out of guidance is a real issue. Women choosing not to accept the care that's being offered, for whatever reason, and the -- and the stress that causes, particularly to community midwives who are caring for high risk women at home, because that's their choice, and that's absolutely right, that they have that choice. But the stress that places on midwives who are -- who know that they're going to a woman who is high risk, is very, very difficult. Particularly women who don't allow the midwife to provide care in the home, they have to speak through doulas or – or aren't allowed to be in the same room or, you know, all of that is -- it's really difficult".* (Staff member)

Postnatal care is a neglected phase of the maternity pathway

After birth — when women are physically recovering, emotionally vulnerable, learning to feed and care for their newborn, and, for some, navigating the transition to parenthood — the care received was described as minimal, rushed, absent, or uncaring. This was particularly when staffing was short, with postnatal wards described as places that made recovery and bonding with babies harder rather than easier.

> *"Post natal ward was dreadful. Loud. Lack of care when needed it. No water available. Terrible place to try and start bonding and breastfeeding your baby."* (Family member)

This matters. The postnatal period is when serious complications for women, birthing people and babies can emerge. It is when the foundations of infant feeding, bonding, and early parenting are laid. This phase of care has lifelong implications for health, wellbeing and the early parent-infant relationship.

Staff reported that the postnatal wards are frequently limited by physical space and staffing levels, making it difficult to provide the level of care needed. Mothers and babies are generally counted as one within activity and demand numbers.

> *"I don't think there is a single maternity service who counts the activity on their postnatal ward as other than the number of women. The number of babies is not counted in the activity or demand. So it's just another example [of underestimation and invisibility] where it's just taken for granted that that's -- that hidden work".* (Kate Brintworth, Chief Midwifery Officer for England)

Postnatal wards in many NHS trusts are physically inadequate. Overcrowding is common. Bay configurations provide little privacy and are largely unsuitable for partners wishing to stay overnight, where this policy exists. In some units, women, birthing people and their babies share space with those who have experienced loss — an arrangement that causes immeasurable distress to all concerned.

Beyond the ward, valuable postnatal community support has been progressively eroded in many parts of England. Women are discharged home, often into a support landscape that cannot meet even their most basic needs. The reality is that postnatal services often stop abruptly at six weeks, even though the needs of women, birthing people and their babies extend well beyond this. Those with complex needs — such as mental health conditions, those with safeguarding challenges, domestic abuse histories, language barriers, or significant social vulnerability — are the most likely to fall through the gaps. These are the most vulnerable people for whom consistent, proactive postnatal contact is most likely to prevent serious harm. The case for a structured, universal postnatal pathway is strong and has been made repeatedly[83] but has not been acted upon at the scale required. This must change.

The six-week postnatal check is a safety net with gaps

Midwifery and health visiting provide the most consistent and important points of contact during the postnatal period, offering continuity of care and holistic assessment for women, birthing people and their babies. Their input is central to supporting recovery, identifying emerging physical and emotional needs, and ensuring timely intervention where required. The six-week postnatal check — offered by GPs — should act as an additional safety net, reinforcing these earlier assessments and providing a further opportunity to review progress and make onward referrals if needed.

Where any part of this pathway is inconsistent or not completed, the overall safety net is weakened. Feedback highlighted variation in both the quality and delivery of the six-week GP check across practices. Completion rates differ and are not routinely reported, indicating an opportunity to improve consistency, strengthen integration across midwifery, health visiting and general practice care, and enhance shared learning to improve postnatal outcomes through support.

The six-week check should be both universal and substantive. For those with complex needs, it should serve as a gateway to enhanced postnatal support, not a substitute for it. It should be flexibly delivered in a format and location that is accessible to women who face additional barriers to attendance — including through home visits for those who need them, and through community-based settings where appropriate. It should not be a model of care that excludes those it most needs to reach.

There is a desire to make changes but this is hampered by current service design

Staff across England are frustrated because they cannot make the changes they need within current service design and configuration. Staff are stretched and struggle to meet the needs of women and birthing people in their care.

> *"I think most people get out of bed every day to do their best, but their best isn't [can't be] good enough, because the system hasn't supported them to be their best".* (Gill Walton, Chief Executive, Royal College of Midwives)

We found little evidence that the varying patterns of service between trusts had been consciously designed, were based on evidence of what works, or had been evaluated nationally. Senior leaders in local trusts wanted support from national organisations to deliver the changes that they felt needed to be made and for those changes to be sustained.

The system is outdated and its design does not match what it needs to deliver

We found widespread variation, fragmentation, and significant gaps in how maternity and neonatal services are currently designed and delivered. This is despite the large number of policies, guidance documents, improvement programmes, and monitoring bodies that already exist.

Maternity and neonatal care is a time-critical clinical environment and the consequences of system failure are often irreversible and can include long term conditions or contribute to the death of a mother or baby. Every element — staffing ratios and role design, estate configuration, antenatal education, triage provision, postnatal care — must be evaluated and updated as a matter of urgency.

We saw trusts making positive changes in response to pressures and changing needs, but these were piecemeal and inconsistent. Different trusts had made different adjustments, with no common framework to ensure that improvements were prioritised, evidence-based, sustained, or transferable.

Workforce pressures create safety risks and prevent high quality care

Throughout the Investigation, we have heard how workforce pressures affect many aspects of maternity and neonatal care. Staff spoke about challenges they faced coping with a range of pressures, including rota gaps, lack of experienced midwifery support, limited senior cover and increased administrative tasks diverting care away from women and families. Workforce planning needs to be redesigned to reflect the realities of modern maternity and neonatal care and to address the significant pressures staff are facing.

High workloads and inappropriate shift patterns are affecting the quality of care

Staff who responded to our workforce survey spoke about the significant workloads they are having to manage and how this impacts negatively on their ability to provide compassionate care to women and families. Sickness absences exacerbated workload pressures due to the need to rely on agency or junior staff.

> *"We have too much to do in too little time. Therefore we cannot provide good quality, safe, compassionate care. Often they get the bare minimum because you literally can do no more before rushing onto the next task. We have too many mums and babies to look after and too many things to do with them."* (Staff member)

Maternity and neonatal services depend on critical and timely decision-making, which can be compromised by fatigue and mental overload arising from system gaps and pressures, such as staff covering multiple roles due to sickness, or unfilled posts. Adding to this, staff described having to work unsustainable shift patterns.

> *"I finished a 24-hour shift yesterday at 6am! 9am-5pm clinic then on call at a community birth & transfer into hospital 8pm-6am [...] what can we do?! I have tried raising this with managers but told there's nothing that can be done to change it!"* (Staff member)
>
> *"Obstetric anaesthesia is, I would say, much less popular than it was 15 years ago [...] there's multiple reasons for this, but I think one of the factors is, is that when they're residents, they have to, during their training, they spend a lot of time working on the labour ward and, out of hours, I think they get a bit worn down by it."* (Dr Nuala Lucas, President, Obstetric Anaesthetists' Association)

Some consultant obstetricians and consultant obstetric anaesthetists described that when on call overnight or at weekends they frequently were required to be present in the unit for the whole on call period. National guidance[84] on compensatory rest for consultants following overnight on call cannot be consistently followed because in many units the consultant workforce is too small to absorb it. This is both a patient safety issue and a workforce sustainability issue.

Neonatal medicine has already moved toward a maximum 12-hour shift model, recognising that protected rest and cognitive capacity are preconditions for safe critical decision-making.

The pressures on staff had a noticeable impact on women and families using maternity and neonatal services, many of whom described delays in receiving pain relief, missed observations and staff who were too busy to provide help such as breastfeeding support. They described witnessing hospital staff who were exhausted, burnt out, sometimes visibly distressed and *"stretched beyond their means"*.

"I felt so sorry for the staff because they were working so hard [...] going hours without food, drink or even a toilet break". (Family member)

"I was pressing the button and I pressed it, and I pressed it, and I pressed it, and no one came." (Family member)

We know that burnout and poor wellbeing are associated with reduced quality and safety of care, higher absenteeism, and higher turnover rates.[85] Stress and strain impair the decision-making and productivity of health and care professionals and can undermine patient safety.[86] [87] Although the effects of long shifts in maternity care are under researched, studies for nurses show negativity, either for nurses, patients or both, with adverse outcomes related to fatigue, which can also jeopardise patient safety.[88] Such fatigue is naturally compounded when staff cannot take regular breaks.

New rota models for maternity services must build in appropriate rest and separate daytime programmed activity from overnight on-call responsibility so that the safety of women and birthing people is prioritised. Rota reform is simultaneously a patient safety imperative, a staff wellbeing issue, and a workforce sustainability challenge.

There is not an agreed approach for senior clinical cover across the 24-hour period

There is no established consensus on the optimal model for delivering consistent senior cover around the clock. What the evidence makes clear is that the quality and availability of senior clinical cover at night must be equivalent to that during the day. The RCOG has recommended 24-hour resident consultant-level presence in the delivery suite of larger hospital units since 2005.[89] This recommendation is not met across much of the country — and the consequences are most acutely felt at night.

"Ten years ago, we had a very clear view from the Royal College of Obs and Gynae that said we should have consultant presence 24 hours a day, seven days a week. We still don't have it. I have been told there's a

> *strong correlation between that data and adverse outcomes".* (National leader)

Achieving this will require more than a policy commitment: it demands a fully funded workforce plan, consideration of the optimum consultant obstetric workforce, and a recognition that the current gaps in out-of-hours senior cover represent an ongoing and preventable risk to women, birthing people and babies.

We heard about increased pressures due to a lack of experienced midwifery staff available on shift

Midwifery staff at several sites commented that the skill mix of staff 'out of hours' was unbalanced with insufficient experienced midwifery staff available. This trend has increased over recent years. Despite the numbers of midwives growing, following increases in student places several years ago,[90] many senior midwives have retired. The number of specialist midwifery posts, which require experienced midwives, but do not normally include working unsocial hours, has increased. In addition, unlike obstetricians, who are still required to be rostered clinically even when in a senior or specialist role, midwives in specialist roles can stop providing direct clinical care relatively early in their careers.

> *"I think it's a real challenge, as [name] said, particularly in midwifery unless you're in an advanced nurse practitioner role. You go into a leadership role, you don't have the time and the capability to be on the shop floor the same."* (Staff member)
>
> *"It feels like all the senior midwives have gone into admin roles."* (Staff member)

Whilst specialist, managerial, education and research midwives make a valuable contribution to the service, we were told that out of hours maternity units are primarily staffed by relatively junior midwives, supported by small numbers of more experienced staff on call. Some hospital and community-based midwives observed that, even during the day, senior midwives were not usually visible or active in clinical areas.

In addition, some roles which would be expected to be undertaken by all midwives, such as supporting bereaved parents are now undertaken by specialist posts. On occasions, families reported that bereavement care was not provided until a specialist midwife was available, with some families waiting until after a weekend to be seen.

Specialist roles, including in bereavement care, were designed to enhance, not replace, care provided by other midwives. Trusts must ensure where specialist posts exist, including in bereavement care and infant feeding, other staff remain sufficiently knowledgeable and skilled so that care is not compromised when specialist midwives are not immediately available.

Capacity pressures result in midwives being moved between services and can restrict choice for women

We were told that delivery suites are frequently under pressure. In response, midwives are moved into delivery suites from community midwifery and postnatal services, leaving these services stretched and, at times, leading to home birth services, midwifery led units, or other community services having to be suspended. This practice has become ‘routine’ in some areas. Community-based midwives reported being anxious about working in delivery suites with staff they did not know or who were too busy to guide them, and with equipment they were not familiar with.

> *“I see the figures of midwives, you know, the numbers going up, but there is still something not right when labour ward gets under real pressure and we call people in from the community, and I think it's a practice that absolutely needs to be stamped out.”* (Professor Nicola Ranger, Chief Executive, Royal College of Nursing)
>
> *“...the postnatal wards have still only got -- they've got five members of staff on a 24 bedded ward. So, that's 24 women and 24 babies, and they are most of the time at capacity. So, how can they provide ongoing care and accept new admissions at the same time as getting ladies out on time, when they've got all that to do, and there's only five of them?”* (Staff member)

The impact of these pressures is that choice of pregnancy and birthing services is sometimes not available to women and families. For example, not being able to give birth at home, being asked to travel to hospitals further away than planned, and limited access to birth pools or epidural pain relief, are a result of these workforce pressures.

> *“I think overall one of the big issues is that the choices for women are decreasing all the time. We’ve suspended home births for six months, which has never, ever, ever happened before.”* (Staff member)

One way of reducing this pressure is by continuing to discharge women and babies as soon as it is safe to do so, into the care of well-resourced community midwifery and other health services that can provide high-quality home-based care. However, in many areas this is not an option as home-based postnatal care services have been eroded and replaced with telephone or clinic-based assessments. It needs to be recognised that postnatal care is as essential to maternity and neonatal safety, as antenatal and birthing care.

Additional burdens place pressure on staff and take time away from giving safe, compassionate care

Staff described a range of competing pressures on their time which made it difficult for them to support women and families effectively. Far too often, we heard accounts of staff grappling with electronic note-taking systems which required inputting the same information multiple times. We also heard about instances where midwives and other staff were required to perform administrative tasks alongside clinical care, for example undertaking reception duties on wards, which meant that they had to interrupt care to let in visitors, or leave women and families waiting to be let into locked wards.

> *"So, when we to talk about safe staffing, it needs to be looked at the whole multidisciplinary team [...] Because often as a shop floor midwife, we end up doing -- I have to do admin, my own clinic, cancelling my clinic because we have no admins [...] So, it really puts pressure."* (National body representative)

Staff and senior leaders also reported being asked to implement time-consuming recommendations which lacked a clear evidence base. This often resulted in recommendations not being implemented or implemented for a short period and then abandoned. This is fundamentally at odds with the NHS commitment to provide 'evidence based' care that is good value for money. In some cases, maternity units have been mandated to implement new recommendations without evidence of their feasibility, clinical, or cost effectiveness.

> *"...how do you keep focused on doing the right thing, and making sure that the changes we make are actually evidence-based, and assessed, and effective, rather than just because somebody thinks it's a good idea."* (Staff member)

Midwives working in all clinical settings should have opportunities to develop extended competencies that are supported and funded

Advanced midwifery practitioner roles exist in some trusts, but there is a lack of consistency in the education and continued professional development for these roles within the scope of practice of a midwife. Regulation of advanced practice for midwives and nurses is currently in development by the NMC.[91] The benefits of such roles include more local care, reduced delays, improved experience of assessment, better use of senior medical time for the most complex decisions, and a clearer, more rewarding career pathway for midwives.

> *"Many midwives are performing quite extended roles when it comes to antenatal clinics, triage and other things. Whereas in other hospitals, those are being done by doctors."* (National body representative)

The pressures of work place a psychological strain on staff

The combination of all of these factors is clearly challenging for staff. An RCM survey of Midwives in 2024[92] found 67% of participants were experiencing work related burnout. An RCOG survey in 2025 found that 65% of obstetricians and gynaecologists were at risk of burnout.[93] Some staff raised concerns about the public vilification and criticism they faced resulting from continual investigations, reviews, media coverage and CQC inspections. During individual interviews undertaken as part of this Investigation, some staff were shaking with anxiety as a result of their experiences of previous CQC interviews.

As mentioned elsewhere in the report, trauma-informed psychological support to families should be provided as a matter of routine practice after women or babies have experienced harm in care. Staff also need psychological or other support but they rarely receive it.

> *"...we need to support and educate and train our workforce to feel confident in providing that care, but there also needs to be a really robust psychological and emotional structure for the workforce to be able to do it properly."* (Alex Mancini, National Lead Nurse for Neonatal Palliative Care)

Workforce planning must be improved and be multidisciplinary

The pressures we highlight demonstrate that workforce planning does not take account of the requirements of the modern maternity and neonatal service. Current tools used for midwifery workforce planning do not recognise the way service needs have changed and how these impact on required staffing levels and wellbeing, which are essential for the delivery of safe maternal and neonatal care.

Workforce planning tools must be adapted to recognise the range of staff involved in women's care, including midwives, obstetricians, anaesthetists, neonatologists, paediatricians, Directors of Public Health, GPs and admin staff and must be developed with their input. Evidenced based ways of workforce planning and working arrangements, supported by agreed safe staffing standards, are required to ensure safe, high-quality care across the continuum of maternity care and to ensure staff can have long and rewarding careers.

> *"Correct resourcing of staffing levels in maternity and neonatal services would probably be the first key thing [...] that would be the most important thing to get right".* (Dr Stephen Wardle, President, British Association of Perinatal Medicine)

Within the tool consideration should be given to:

- Providing continuity of care for antenatal and postnatal services
- The increasing number of post-surgical women, birthing people and babies with additional needs on postnatal wards
- The need for obstetric consultants and anaesthetists to be available for a delivery unit for timely critical senior decision making and intervention 24 hours a day, 7 days a week shift working for medical consultants in maternity units, as is already seen in A&E and Intensive Therapy Unit (ITU) environments
- The development of multidisciplinary structured rotas with fixed rotating shifts, balancing the skill mix of midwives across the 24-hour period
- A review of the appropriateness of 12-hour shifts for all staff groups
- Ensuring care is not compromised when specialist midwives are unavailable and that senior midwifery staff are supported to remain visible and clinically active alongside their managerial responsibilities
- The provision of support staff, for example administrative staff and receptionists
- Access to breaks.

Governance, oversight, and accountability arrangements are failing to support high quality care

Maternity and neonatal services operate within a complex set of governance, oversight, and accountability arrangements. These are intended to ensure that any risks to the delivery of safe care are identified early and appropriate mitigations put in place to prevent avoidable harm from occurring. In addition, they have a role in ensuring that effective processes are in place to respond to safety concerns and/or failures in care. They are about making sure that the system protects the people it is there to help. Terms such as 'governance', 'oversight' and 'accountability' can seem distant from everyday practice and care and are sometimes used interchangeably but they are different although interconnected:

- Governance is the umbrella term for the processes in place to monitor and oversee that decisions are made, services are working properly, and improvement happens after problems are identified.
- Oversight is the supervision and management that takes place to ensure that processes are followed correctly and services are provided safely. This includes assurance (internal evaluation of performance) as well as regulation (external inspection to ensure standards and requirements are being met).
- Accountability is about owning and being answerable for decisions made and actions taken. It is about what happens when individuals or teams make mistakes or fail to act fast enough. It includes taking responsibility for the resulting impact, outcomes, or effectiveness of decisions and actions.

These structures are central to people's experience of care and should give reassurance that those delivering essential services are doing so in a consistent, safe, and equitable way.

Governance, oversight, and accountability mechanisms operate at a local trust level, at a regional level, and at a national level. At a local level, NHS Trust boards hold primary accountability for maternity and neonatal services. Regionally, NHSE oversee maternity services, and neonatal services (including specialist transport services) are coordinated through 10 Operational Delivery Networks (ODNs). NHSE provide national oversight for maternity and neonatal services. Where concerns about maternity and neonatal services cannot be managed locally, they are currently escalated to NHSE.

A key finding of our Investigation is that the governance, accountability and oversight mechanisms in maternity and neonatal care are confused. Many staff do not understand how the different arrangements fit together and families are understandably mystified by it.

Why it matters to women, birthing people, and families

For women, birthing people and families, governance, oversight and accountability are words that may seem abstract and distant, but they matter because they shape the way that care is delivered, whether concerns are taken seriously, and what happens when things go wrong. When these mechanisms fail, harm is more likely to happen repeatedly and over prolonged periods of time to multiple women, birthing people, and families. Relationships between patients and staff are likely to be damaged, and learning is less likely to take place. It is a continued source of pain and trauma to families we spoke to that they have had to navigate complex systems which lack openness and transparency to get the justice they seek.

Families described complaints, reviews, and investigation processes as slow, opaque, and difficult to navigate. Many said they had to chase for answers repeatedly, retell painful experiences to different people, and wait for long periods of time for explanations to be given, meetings to be set up, and documents shared. The different types of investigation added complexity with a lack of coordination between local complaints, serious incident reviews, coroners and ombudsman investigations, and other legal processes. One mother told us that she had to become a medical and legal expert when she was looking for answers whilst grieving the death of her baby. The psychological harm inflicted on families is not recognised, leaving them with inadequate or inappropriate support. We covered this further in the section on when things go wrong.

"The process felt complicated, unfriendly, and inaccessible to bereaved parents." (Family member)

"…what should've been five years of grieving was in fact five years of fighting for the truth." (Family member)

It is no wonder that families distrust the accountability mechanisms which are in place. Something that should be straightforward and which should help families understand how and why things went wrong, has become a problem. Families who have faced harm, bereavement and poor treatment have lost trust. Families described serious breaches of confidentiality, including sensitive information being shared inappropriately or records being handled in ways that felt unsafe. If families cannot rely on the basic information being right, how can they be expected to have confidence that accountability processes are fair? And many families only received an apology after media scrutiny, external investigation, coronial review, or legal action, deepening their sense of mistrust as they fought for honesty and transparency. They rightly ask why it is hard to say sorry.

"…trust for all of us is something that's really difficult for us to give now because of what we've been through. I'm left in a position where I don't

> *trust anyone anymore. And that's really, really sad. I genuinely don't trust anyone."* (Family member)
>
> *"I trusted the whole care profession, but the system let me down. Unqualified, unsupervised staff caused lifelong damage."* (Family member)

Some progress has been made in national, regional, and local arrangements

NHSE is the organisation that holds ultimate accountability for ensuring good health outcomes from maternity and neonatal services and ensuring consistently high-quality care. NHSE devolves that responsibility and accountability to regions and ICBs.[94] At local level, trust boards are accountable for the maternity and neonatal services in their area, as they are for the other specialties delivering care across the Trust.

> *"…we have very high expectations of each trust to be accountable for the services that they provide. So the trust executive board should have close oversight and accountability for what's going on in its maternity service, working in very close partnership and support of its maternity service".*
> (Kate Brintworth, Chief Midwifery Officer for England)

Interviews with executive and senior leaders during our site visits, virtual meetings, and a review of governance documents provided by them showed the increasing priority and visibility of maternity and neonatal services to trust boards in recent years. We were told about, and reviewed, documents relating to new governance structures which had been established. We reviewed maternity-specific reports targeted at strengthening the oversight and assurance provided to boards about the safety and quality of maternity and neonatal services.

In some trusts we visited, board members and executive leaders engaged in regular, structured walkabouts of maternity and neonatal services to hear first-hand from women, birthing people, and families about their experiences, and to speak to staff about safety concerns and ensure that they are acted on.

In addition to those maternity-specific reports, we reviewed dashboards which contained important clinical and other measures to support trust board, regional, and national oversight of maternity and neonatal services. These dashboards contain important performance measures that directly relate to women's experiences of care: for example, delays in induction of labour and impact of closure of home birth services or units. Regional and national leaders also told us about other dashboards newly developed or being finalised, including for equalities, to help target improvements in maternity and neonatal services, and to provide real time experience measures.

> *"...it's only really in the last sort of maybe four years that we've got much more visibility on maternity data at a system level. And that is predominantly due to [...] having sort of system dashboards that didn't exist prior."* (Integrated Care Board member)
>
> *"...finishing the performance dashboard [...] has felt like a really important moment because everybody knows about four-hour waits, everyone knows about referral to treatment time [...] but not everyone knows about delayed induction of labour and delayed caesarean sections [...] those things are so important, because absolutely everything we do in maternity is time critical".* (National leader)

Another change evident from our trust visits and interviews with regional and national leaders was an increasing recognition of the interplay between maternity and neonatal services and the need for the services to manage issues together with, for example, separate maternity and neonatal governance committees at trust level becoming perinatal committees and, at regional and national level, establishment of perinatal oversight groups.

> *"...at times maternity in the past has been siloed. Because it's a rather peculiarly specialised area, it ended up with a little bit of maternity absorbing its own smoke [...] maternity sits in a broader organisation and the really high performing organisations get that and it runs all the way through to the board. The chief nurse knows everyone in maternity, the medical director knows everyone in maternity, the chief executive knows everyone in maternity, and you see that easy flow of information and support".* (Kate Brintworth, Chief Midwifery Officer for England)

But despite this increased focus on maternity and neonatal services working together in trusts, the experiences of women and families show that this has not yet translated into a service that consistently provides safe, quality care. Progress remains fragmented.

Structures and processes are complex, confusing, and burdensome

It is clear that the lines of accountability and responsibility set out in policy documents for maternity services are not working.

> *"...[from] a trust perspective [...] this is a really complex [...] landscape [...with] too many organisations on the pitch. We've [...added] over time [...] layer[s...of] additional scrutiny, because we've reacted to a set of inquiries [...] and not delayered at the same time [...] we've still got a lot of*

> *delayering […] to do."* (Duncan Burton, Chief Nursing Officer for England)

> *"Somehow as a country we have created a very, very muddled system and we do have the clear lines of responsibility and accountability, but you wouldn't necessarily know it […] We have somehow allowed a plethora of other organisations to grow […] which […] have confused and actually therefore diffused responsibility and accountability."* (Dr Penny Dash, Chair, NHS England)

The sheer volume of data and information about maternity and neonatal care that trust boards and governance groups are required to provide, read, interpret, and assess is challenging and is not necessarily resulting in safer care.

> *"The growing insight, the intelligence, everything that we can do […] feeling sometimes a bit overburdened by it."* (Integrated Care Board member)

During our trust visits, senior clinicians and managers told us about the considerable time and effort dedicated to governance and oversight activities, including collating data from across different sources, preparing for trust and stakeholder meetings, producing reports, and interpreting and analysing data. These responsibilities have grown considerably in recent years, with frequent changes in requirements and increasing demands from multiple different stakeholders.

Midwives are responsible for a large amount of this governance and assurance work, often with little or no data analysis or administrative support. Junior staff spoke about the governance demands on senior midwifery staff, which limited their ability to help with care needs at times of high demand or pressure. Many saw assurance needs as competing with care needs.

> *"I think our leaders, our maternity leaders have felt overwhelmed with the transformation programmes in maternity and the work that they need to do around that, the recommendations and the action plans that they've held and their own local, you know, their own local improvements that they have to do [as well as keep] their business-as-usual running."* (Integrated Care Board member)

The availability of good data is central to governance, oversight, and accountability but timely and accessible information is often lacking, incomplete or inadequate and does not assist with identifying risks early.

> *"There is quite a lag sometimes in the national data set, which sort of has proven to limit some of the identification of risk and patient safety issues [...] getting some of those data sets isn't always that easy at a local level."* (Integrated Care Board member)

Families expressed concern about trusts assessing their own performance and 'marking their own homework'. The importance of trust culture, the quality of relationships, and lived experience was highlighted as vital to assess alongside other performance metrics and statistical information. For families, the qualitative matters as much as the quantitative.

> *"I think some of the system oversight for maternity and neonatal services remains a bit inconsistent. And I think there is quite a bit of overreliance on the providers undertaking that sort of self-assessment."* (Integrated Care Board member)
>
> *"There is nothing that supplements having a relationship with chief nurse, going and meeting her in her environment, walking around those high-risk areas, having her trust and her trusting you to be a trusted ally in telling her when things are not, you know, when you see something, versus a template."* (Integrated Care Board member)
>
> *"...if you only focus on metrics you're going to miss a huge element of what it is that makes that organisation turn over in a particular way."* (Kate Brintworth, Chief Midwifery Officer for England)

Recommendations should be prioritised

Key to accountability is what changes after a review or investigation has taken place. We consistently heard from senior leaders in trusts that the number of recommendations directed at maternity and neonatal services are overwhelming and take time to implement.

> *"They came in thick and fast, all behind each other, didn't they? You know, you barely have one set of recommendations before the next and then where was the priority?"* (Integrated Care Board member)
>
> *"There's been so many reviews and so many outputs that you then build this never-ending action plan".* (Integrated Care Board member)

An additional challenge was that the recommendations had not been prioritised nationally, so in effect, all needed to be implemented immediately. There are currently over 700 recommendations on the National Maternity and Neonatal Recommendations register and many of them overlap (This is explored in detail at Annex 3: A rapid review of previous recommendations for maternity and neonatal care).

"The number of recommendations is just unmanageable and it's really difficult to keep oversight on progress on all of -- all of the different recommendations. I thought the three-year plan was supposed to pull everything into one, but we're still being monitored on all of them, as well as the three-year plan. So it's a challenge." (Trust senior leader)

"...we just can't keep implementing recommendation after recommendation after recommendation". (Integrated Care Board member)

Our findings echo that of other Investigations. HSSIB identified a systemic weakness within healthcare governance as the generation of recommendations is not matched by equivalent mechanisms for implementation, oversight, and impact evaluation. Across both its national review of healthcare recommendations[95] and its exploratory review of maternity and neonatal services,[96] HSSIB highlights that the inability to implement recommendations effectively can perpetuate known risks, compound patient harm, undermine public confidence, and limit the healthcare system's ability to learn and improve.

"Pressures on our maternity teams to be busy collecting data and maybe missing the point a little bit." (Integrated Care Board member)

This is a high-risk transitional moment as NHS accountability and governance structures are changing with some concerns raised that the mechanisms and structures put in place to improve and monitor trust services will be lost, before new arrangements are fully established.

"I think at the moment now is one of the riskiest times possible in terms of that oversight." (Integrated Care Board member)

"I'm really worried without the LMNS team, because my team are all going now [...] that that focus and that constant driving of looking at inequalities [...] will be lost [...] the actual capacity for maternity services to do that work [...] I think is going to be really limited". (Integrated Care Board member)

There is a lack of confidence, consistency, and expertise in regulation

CQC is the regulator of the quality and safety of services for maternity and neonatal services, as part of their regulatory obligations for healthcare providers. Families spoke passionately about what they saw as the mismatch between ratings and their experience. Early on in our Investigation, families pushed for an in-depth investigation of regulatory bodies to be included in the terms of reference, prompting a letter from the Chair of the Investigation to the Secretary of State for Health and Social Care, highlighting family concerns.

> *"How can I go into a unit that is rated good and has convinced people that recommendations have been met, including the CQC? So the CQC thought it was rated good [...] And it wasn't, essentially."* (Family member)
>
> *"I struggle to reconcile how a unit that is inadequate or requires improvement for safety can get an overall rating that is higher than their safety rating. If a unit isn't safe, what else matters?"* (Family member)
>
> *"Coming onto the CQC [...] for years, families [...] have been raising concerns and trying to get their voices heard while the maternity service continued to be rated as good by the CQC."* (Family member)

All of the 12 NHS trusts we visited had been investigated by CQC with a range of ratings for their maternity and neonatal services,[97] ranging from 'Outstanding' to 'Inadequate'.

Views differ on how well CQC perform their regulatory function in relation to identifying trusts that are not meeting required standards. Some trusts reported working well with CQC, describing the support they received when working to enhance the quality and safety of their services. Other trusts found CQC unhelpful and said that relationships could be strained.

> *"We are finding it at present tense, incredibly difficult to work with the CQC to get them to change their opinion on things that they cannot factually evidence".* (Trust senior leader)

The overall view was that the CQC regulatory framework was inconsistent and subject to significant regional variation. Trusts were not always clear about the standards they were being asked to achieve and commented that the standard could change without warning. We were given examples where judgements of trust performance changed quickly and for reasons that trusts did not understand during the assessment process.

> *"I think sometimes it would be helpful to feel like maybe we had a bit more of a voice in what the action plans are from these sorts of investigations, and what's achievable. Because sometimes it feels a little bit like it's change for change sake, without* necessarily the data behind it." (Trust senior leader)

There was also a perception that CQC lacked the expertise in the area of maternity services to make a proper assessment of services. It was acknowledged by CQC that they were actively looking to address this, with the intention of bringing maternity services under closer scrutiny.

> *"…sometime between 2021 and 2024, things went seriously downhill at CQC. So the first thing that happened was they went back to having a single inspection directorate not specialising. So you could have somebody inspecting a care home one day and a maternity service or intensive care unit the next without the expertise."* (Professor Sir Mike Richards, former Chair, Care Quality Commission)
>
> *"…for the round of inspections of maternity specifically, that was done in 2022 to 2023 […] there weren't sufficient external professional advisors, either obstetricians or midwives."* (Professor Sir Mike Richards, former Chair, Care Quality Commission)
>
> *"…we are advertising to recruit more specialist advisors in maternity: midwives, obstetricians and in neonates […] we need to get more expertise into the inspection programme […] I don't think we can inspect without our specialist opinion. That will allow us to identify whether this maternity provider is a good unit or not a good unit".* (Dr Toli Onon, Chief Inspector of Hospitals, Care Quality Commission)

We are particularly concerned that the level of expertise in CQC to develop a sufficiently sensitive methodology for assessing the safe functioning of maternity and neonatal services is not present. We heard instances during our site visits of CQC instructing that actions take place which were not in line with recognised best practice. We do not consider that CQC has credibility as the regulator of maternity and neonatal care with clinical teams, executive teams, or families. There is one recent example of a maternity service being rated as 'Good' where a number of serious safety concerns were raised with us, bringing the rating into question.

We recognise that the CQC is on its own improvement journey and are aware that it must address the failings identified in the Dash review.[98] But it is unrealistic to expect an organisation under significant pressure to improve without stable leadership. Following the resignation of its Chief Executive in October 2025 with immediate effect, there is still no substantive Chief Executive in place. At the time of writing, CQC is also operating with an interim Chair. CQC is not providing the level of regulatory oversight that it should be for maternity and neonatal services, raising significant concerns and questions about its effectiveness in regulating maternity and neonatal services.

In addition to our concerns about CQC itself, we are concerned that there has been insufficient oversight of its performance and operation by the DHSC. DHSC has recognised performance and effectiveness issues at CQC, including taking action to commission three separate independent reviews in 2024.[99] [100] [101] However, we saw limited evidence during our Investigation that this has addressed the significant problems that CQC continues to experience.

System governance and accountability structures must be clarified, and the effectiveness of regulatory oversight must be improved

A streamlined, national oversight and leadership model must be put in place so that clear lines of governance, accountability and escalation are in place at all levels of the maternity and neonatal system. Steps must be taken immediately to improve the regulatory oversight provided by CQC and other relevant bodies and to give confidence to families.

For women, birthing people, and families these structural problems are not abstract. They have real consequences. They shape whether concerns are heard, whether harm is acknowledged, whether complaints are dealt with openly and quickly, and whether lessons are learned in real time to prevent the same harm happening again. Ultimately, these structures are not delivering the accountability that women, birthing people, and families seek.

Leadership, teamworking and culture must improve to ensure care quality and safety are prioritised

Throughout our Investigation the importance of credible, effective and principled leadership in driving change has been a consistent theme from families and staff. Strong leadership and effective team working are essential in any well-run organisation. A team of motivated professionals, who understand their individual roles and responsibilities, with common goals, clear objectives, and a focus on learning rather than on blame, helps to create a supportive culture. A culture that delivers the best quality care is one which is supportive of staff and where there is good communication. Organisational culture is shaped by the nature of its leadership. The behaviour of leaders – from the top to the bottom of the organisation, individually and collectively – is crucial in creating an environment where care quality and safety is given priority. Where there is effective people management, there are high levels of staff engagement, learning and quality improvement processes are embedded, and good team and inter-team working is a given.[102] But too often during the period of our Investigation, we found that this was not the case.

NHS trust leadership

The quality of leadership at trust level has a direct impact on patient safety, staff experience and team functioning. Staff spoke about strong leadership driving improvements in care. In some trusts, staff described the active engagement and support of the executive and senior leadership team, along with strong clinical leaders, as giving stability and providing the foundation on which change could be made. In one Trust, we were struck by the way leaders openly and honestly acknowledged the challenges facing their maternity and neonatal services and their demonstrable, collective commitment to improvement. Staff described the importance of leadership teams that were visible, engaged and focused on learning. While it was clear that progress was at times slow and significant challenges remained, there was evidence that this approach was beginning to deliver meaningful improvements.

This example demonstrated to us that positive cultures can be developed even in the most difficult circumstances. When leaders model openness, collaboration, and accountability, staff trust the leadership and are committed to the improvement journey.

> *“I've been a midwife for 20 years in this Trust. So I've seen lots of matrons, like managers all coming through. I think the management team we've got now are really good. We've seen lots and lots of changes. Lots of changes all for the better. We've still got lots of things to do. We've still got a long way to go. But there is some huge, huge differences in our service already”.* (Staff member)

In other trusts, we heard from staff how the quality of the leadership can have an impact on safety and outcomes for women and families. Some staff highlighted a disconnect between leadership and frontline realities, sometimes characterised by a perceived prioritisation of financial targets over clinical needs and staff wellbeing.

> *"The team of midwives cares about patient safety and quality of care provided but unfortunately this is not supported by the senior leadership team. We keep the unit safe but we are belittled when we escalate that is unsafe and we are told we are being too negative and obstructive"* (Staff member)
>
> *"We're being held to account on finances all the time, which we understand is very important, but the processes around all the things are barriers to making change and doing the right thing for our women."* (Staff member)

Clinical leadership plays a key role in care and culture

Clinical leaders play a critical role in shaping the care and culture in clinical areas. They are often required to manage complex services, support staff, oversee quality improvement and respond to operational pressures. Staff highlighted that newly appointed clinical leaders are frequently expected to manage teams and services without sufficient preparation, support or formal leadership development or training in people management. This does not contribute to stability, yet clinical leadership is central to how services function, to improving quality, and identifying and addressing failures in standards.

We also heard concerns about the sustainability of some leadership arrangements. Clinical Director positions were sometimes described as difficult to recruit to and the staff who accepted the roles difficult to retain, with frequent turnover of leadership and a lack of continuity. Staff said that there are often insufficient administrative support and limited protected time to fulfil leadership responsibilities effectively.

> *"...this constant changing of clinical leadership [...] we've now been told they're going to change every 18 months. That's ridiculous. You're never going to make any progress like that."* (National clinical leader)

Midwifery leadership is a critical factor in influencing team morale and the culture in maternity services which in turn impacts on the care provided to women and families. As discussed earlier, a significant theme was the importance of senior midwifery leaders remaining involved in frontline clinical practice. When midwifery leaders continue to practice clinically, they are visible and accessible to staff, have more credibility through continued provision of clinical support and see first-hand the daily realities and pressures facing staff. Good clinical leadership includes a willingness to listen to concerns, acknowledge challenges openly and work collaboratively across professional groups. Staff working in units with these factors in place frequently described higher levels of trust and greater confidence in their leadership teams, with greater overall work satisfaction. This approach was evident in some but not all trusts.

> *"...seeing our management on the unit more [...] you know, they're all visual. They all do muck in. If we are short staffed, they come out and help, you know, with all kinds of things [...] I've only literally had to call and text or whatever, just knock on their door, you know, it's nothing's been too much for them to help me".* (Staff member)
>
> *"Going back to the head of department, who you've not seen, anyone else that I think that has taken up that sort of senior leadership role should be visible, should be approachable, should be made accountable to the staff so we could voice our concerns. I actually wouldn't know how to. I probably could search for him on the Internet, but if I needed to speak to him, I wouldn't know where to go."* (Staff member)

Effective teamworking and communication is essential to families' experiences

Many families described poor teamworking and communication between professionals and across services, particularly between midwives and doctors and between different trusts. This led to mixed messages, delays in and, at times, unsafe decision-making about their care. Several families described watching staff and experienced professionals disagreeing in front of them. At a time when families are feeling vulnerable, this increases stress and anxiety.

> *"The midwife and the doctor stood in front of me arguing [...] It was very mixed messages and just no coherent plan."* (Family member)
>
> *"They don't want to be seen by the doctors as not knowing what to do, so they didn't raise the alarm."* (Family member)

National and regional leaders observed tension between different professional groups, particularly between obstetricians and midwives.

> *"I think we've got an inherent level of [professional] tribalism that we haven't acknowledged, which can be dysfunctional."* (Sir Jim Mackey, Chief Executive Officer, NHS England)

Lack of clarity of reporting lines and oversight mechanisms also create barriers between professions, for example maternity and neonatal services being managed differently was cited as creating barriers to communication and a shared sense of responsibility.

> *"...when the maternity governance and the structures within the trust, divisions, directorates are different from neonatal ones, that can create some barriers and walls that affect communication."* (Dr Stephen Wardle, President, British Association of Perinatal Medicine)
>
> *"So, there's obviously the Royal College of Obstetrics and Gynaecology, where most obstetricians would have trained through that, almost all obstetricians would have trained through that. There's the Royal College of Paediatrics and Child Health, which is where the neonatal side comes from. Then there's the midwives who are trained by a completely different route."* (Professor Sir Chris Whitty, Chief Medical Officer for England)

Effective multidisciplinary team working, with leadership integrated within and across professions and with non-clinical leaders, is an essential part of a safe and compassionate service. Teams need stable membership, with reflection and learning time involving all members. Informal social contact, such as shared breaks, also help to build cohesion and psychological safety.[103]

Psychological safety is vital for staff who must feel safe to escalate concerns

It is important that staff feel safe to escalate concerns about care in their trusts. In our staff survey, consultants highlighted leadership challenges, referring to cultures of blame, fear and top-down management which led to low staff morale and trust. Strong, visible leadership that actively listens to frontline concerns and fosters a non-punitive culture was frequently cited as essential for maintaining morale and empowering staff to speak up.

A consultant described their experience of speaking out against a *"toxic jack boot culture"*, saying *"to challenge any of the things that are done within the unit [...] is unacceptable. If this happens, then you become singled out and you become subject to, basically what happened to me, a witch hunt"*.

> *"We weren't qualified midwives, but we were being used as second midwives, which made the midwives feel quite uncomfortable. And it was escalated quite a few times, but it would just get, "Do you want to get us closed down, do you want to lose your jobs?", all the time"* (Staff member)

> *"...a culture of blame still exists [...] people are fearful of speaking up, people are fearful of the implications of speaking up on their jobs and their roles"* (Rosie Benneyworth, Interim Chief Executive Officer, Health Services Safety Investigations Body)

In our interview with the GMC worrying data was highlighted: 27% of obstetrics and gynaecology trainees reported being hesitant to escalate concerns, a signal of poor leadership[104] and which could lead to increases in patient harm.

In recognising the importance of fostering cultures which are about learning rather than blame, we are not endorsing lack of action in relation to transgressive behaviour. Transgressive behaviour typically takes the form of abusive behaviour, sometimes by established, senior staff, which may involve bullying, discrimination and racism. We heard about consistently poor behaviours from professionals being known about by trust leadership over decades but not dealt with. These behaviours can impact the safety of services delivered to women and babies. This echoes what has been found in other national inquiries and investigations and leads us to conclude this is a critical patient safety issue. Staff need to see this behaviour called out as unacceptable.

Professional competency or seniority is not an excuse for poor behaviour. To address these challenging professional conduct and relationship issues, relevant Human Resources (HR) policies that underpin expected behaviour in the NHS should be reviewed through the lens of putting patient safety at the centre of all considerations.

In the Investigation's staff survey, in response to the question 'what supports you to provide high-quality, safe and compassionate care at work?' a staff member said: *"A framework that supports tackling poor practice and/or bad behaviour, including HR backing where needed."*

Compassion fatigue can result from pressures on staff

Throughout our Investigation families raised concerns about staff displaying a lack of compassion towards them. Along with the lack of listening to women, it was the issue that most families consistently raised with us.

> *"...absolute lack of compassion [...] I was probably actively losing a baby [...] and they really, really didn't seem bothered [...] it was like really I was inconveniencing them."* (Family member)

Staff also recognised this and often attributed a lack of compassion to pressures and demands on their time.

> *"We are constantly understaffed and this has an impact on absolutely everything else [...] The morale of staff is rock bottom so they have no*

> *desire to learn and read creatively around the topic of midwifery outside of work so very little changes. It also means that we have less capacity to be compassionate whilst at work. When you are spread too thinly it means that nobody gets good care, not the women or the staff."* (Staff member)

In both this report and the Interim Report published in February, we outline the pressures on staff, but that this is not an excuse for treating women and families with a lack of kindness or compassion.

> *"...somehow they lose sight of the fact that no matter what they know about the situation, for that person giving birth [...] the parents, it's the most important moment of their lives and they're confused about it. They don't understand what's happening, so they lose sight of that and that -- losing sight of that leads them to communicate in a way that they themselves wouldn't want to be communicated with."* (Professor Jeremy Howick, Director, Stoneygate Centre for Empathic Healthcare)

Staff explained that a lack of compassion is partly due to the stresses associated with the job, *"there's no way around the fact that it's a tough job [...] stress inhibits empathy. When people are under stress, in the fight or flight response, thinking about others. thinking about their own survival."*

Just as compassion can be eroded over time, it can be restored. Empathy training for staff of all grades can "*change outcomes ranging from patient satisfaction to lower pain*" by helping participants understand the reasons behind the erosion of compassion, and the things they can do to help. For example "*introduce yourself by name [...] sitting down [...] don't interrupt the patient*". There are simple and effective steps that can be taken to show attention to families.

Skills and training should foster a positive team working culture

Making sure that staff have the right skills and training to undertake their roles was raised repeatedly by staff.

> *"When you come from a Band 6 clinical role and you go any Band 7 role, you actually have no training in NHS for leadership at all for management. You literally have nothing, and you go from a clinical role to then managing people".* (Staff member)

Training can support or hinder joint working, but current models of training for doctors, midwives and nurses often create barriers to mutual trust and understanding. This applies across maternity and neonatal care. Undergraduate education usually takes place separately, often in different institutions, with different commissioning routes and separate curricula. As a result, professions may have little opportunity to learn how to work effectively together before entering high-pressure clinical roles. While student midwives often work with trainee and consultant obstetricians early in training, medical students usually do not routinely work with midwives.

Undergraduate medical students need a broad understanding of pregnancy and childbirth, they do not need specialist obstetric and gynaecological expertise.[105] Student midwives need in-depth understanding of physiological pregnancy and childbirth, as well as how to provide care to women and birthing people with more complex needs. For doctors, specialist knowledge develops later through postgraduate training. All clinical professionals must take part in continuing professional development, but requirements differ.

> *"I think there is significant opportunity for medical education, for the education of nurses and midwives and other relevant professions, to be involved together in learning. So, I think that multi and inter-disciplinary learning right at the beginning of people's educational journey through their primary qualification, pre-registration, is key [...] the starting point for all placement opportunities and education at an undergraduate level should be multi and inter-disciplinary, not uni-disciplinary. If there are some things that need to be delivered, sorry, that need to be managed separately as exceptions, then okay, but the core learning that midwives and undergraduate doctors need to experience should be done together."* (Professor Simon Brake, Chief Engagement and Innovation Officer, University of Warwick medical school)

Staff told us that postgraduate training and education are inconsistent with areas of training lacking particularly in relation to multidisciplinary working and trauma-informed care. Workforce development is also constrained across education and service settings with staff reporting too little time for post-registration training, uneven access to continuing professional development, and limited chances to build advanced clinical skills. Staff also described pre-registration midwifery education as lacking time for reflection, critical thinking and consolidation. Workload and staffing pressures also reduce time for supervision, assessment and support in practice, and limit protected learning time after qualification.

Postgraduate medical education and midwifery education are already subject to an NHSE review. This review should take into account the particular needs of maternity services and the links with midwifery. There should be, without delay, a separate, multidisciplinary review of maternity and neonatal education, with particular reference to the need to maximise opportunities for joint curriculum development, joint participation in elements of training, and joint experience of the practical aspects of maternity and neonatal training.

Normal birth ideology, informed choice and safe escalation

Our Terms of Reference asked us to report on the extent to which a ‘normal birth ideology’ currently exists in maternity services. This is a contested concept. There is no single agreed definition of either ‘normal birth ideology’ or ‘normal birth’, and the terms have been used in different ways by families, staff, professional bodies, previous investigations and commentators.

Previous maternity investigations have raised serious concerns about the inappropriate pursuit of normal birth, including situations where the safety of the mother or baby was not given sufficient weight. The Morecambe Bay Investigation referred to *“normal birth at any cost”*, suggesting extreme views in which staff disregard safety to prioritise birth without medical intervention. Subsequent reports have described circumstances in which staff preference for physiological birth appeared to contribute to delayed escalation, delayed medical interventions or failure to respond to changing risk.

Where it is safe to support physiological birth and it has been chosen by the woman or birthing person, this should be done in collaboration between the woman and staff. The safety concern arises where any professional belief or service culture which favours physiological birth leads women and families to be steered towards or away from particular choices without balanced information, informed consent, dynamic risk assessment and timely escalation.

The evidence we gathered did not allow us to determine the national prevalence of normal birth ideology. However, we heard examples where failure to recognise problems and escalate them appropriately resulted in harm. What we did hear from families was that some women and birthing people continued to feel pressured or steered towards particular approaches to birth, and that their individual preferences, concerns or changing clinical circumstances were not always fully recognised.

> *“It was like, ‘We can do this as midwives together. You know, we don’t need the doctors’ [...] It was this like, hero, you know, we can do all of this’.”* (Family member)

We also heard from women who felt pushed towards intervention without adequate discussion of their preferences or the evidence base.

Midwifery and obstetric staff in the trusts we visited told us that they did not recognise a ‘normal birth at any cost’ ideology being present in their own units. We did not observe evidence of this during site visits or hear about it on staff panels. An experienced delivery suite coordinator was clear she had not experienced ‘normal birth ideology’.

> *"I don't recognise it. When I read that midwives don't call in the doctors if they're worried and stuff, I've never seen it. I've never felt it. I've never seen it. Ever. So, we absolutely do not have that here, and I can say that with my hand on my heart."* (Staff member)

Accounts of women feeling pressurised point to a wider safety issue: women and birthing people must be supported to make informed decisions, based on clear, balanced and evidence-based information, with risk reassessed throughout pregnancy and labour. Care should not be shaped by fixed assumptions about the 'ideal' type of birth, this includes assumptions that favour either physiological birth or the use of non-evidence based or unnecessary obstetric interventions. Decisions should instead be made through shared decision making between women and maternity staff, taking into account the best available evidence, the woman's preferences, and her individual clinical circumstances.

We commissioned a review of university midwifery course materials to understand how normal birth was presented in education. This found that 46 of 61 courses included reference to 'normal birth'. This is not unexpected, given the importance of teaching the physiology of pregnancy and childbirth. However, some course materials included phrases such as *"rooted in normality"* and *"rooted in promoting physiological birth"*, which could be interpreted in different ways if not clearly contextualised. The NMC also reviewed approved education institutions and found no evidence of 'normal birth ideology' being taught within pre-registration midwifery programmes but emphasised that the word 'normal' must be properly contextualised so that its meaning is not misunderstood.

On the evidence available to us, we did not find that 'normal birth ideology' was currently widespread in the maternity services we visited in England. This should not dismiss the concerns of families who shared personal experience or the findings from previous investigations. The most important aspect is to ensure all women, birthing people and their babies receive safe, high-quality care, and that their birth choices are listened to and respected. This should be achieved by implementing the recommendations in this report on listening to women and birthing people, provision of informed choice, shared decision making, dynamic risk assessment, timely escalation, effective multidisciplinary teamworking and improved education.

Culture and teamworking must be improved and leadership strengthened at all levels of the system and across professions

Throughout our Investigation the need for strengthened local leadership, improved multidisciplinary teamworking and greater professional understanding between midwives, obstetricians, neonatologists, anaesthetists, paediatricians and other professionals involved in maternity and neonatal care was raised.

Achieving these improvements requires action across leadership development, workforce planning, organisational culture and professional education. Education and training at all stages of a clinician's career should place greater emphasis on compassionate care, communication, multidisciplinary working, responding appropriately to adverse events and fostering cultures of learning and continuous improvement.

The physical and digital infrastructure is undermining safety and the delivery of high quality, compassionate care

The physical environments where care takes place, alongside the digital systems that support it, are fundamental to safety, dignity and the overall experience of maternity and neonatal care for women, birthing people and families, and to staff wellbeing and their ability to deliver care safely and effectively.

Poorly maintained buildings, overcrowded spaces and fragmented digital systems affect how safe people feel, how effectively staff can work, and whether care can be delivered in a way that is private, respectful and reliable. Poor design makes it harder to rest, recover, move around safely, or stay together as a family. They also affect emotional wellbeing: for women and families at some of the most significant and sometimes distressing moments of their lives; and for staff working in pressured, poorly maintained or unsuitable environments.

While most of what we saw and heard relates to hospital-based care, these experiences reflect wider issues affecting women, birthing people, families and staff across maternity and neonatal services. We also saw examples of improvement and good practice. However, the overall picture is that physical and digital infrastructure does not yet consistently support the standard of safe, compassionate and personalised care that services are trying to provide.

Physical environments impact on dignity, privacy and emotional wellbeing

Families described hospitals, wards and units that are outdated, overcrowded and not fit for purpose. They highlighted cramped multi-bed bays, a lack of side rooms (including for bereavement care) and noisy environments, rooms with poor ventilation and limited natural light. A lack of private spaces affected confidentiality with sensitive conversations sometimes taking place where others could overhear.

Some women described difficulty getting to the toilet, moving around the ward or managing basic needs, particularly after a difficult birth or surgery. Others raised concerns about inadequate facilities, including access to food, drink, rest areas and space to put personal belongings.

> *"It was a very hot, July day and she was in a crowded postnatal ward. It was airless, noisy, and cluttered […] She had been offered nothing to eat, nor a cup of tea".* (Family member)

Many women and birthing people described feeling unwelcome when they arrived to use maternity or neonatal services. In some cases, they were asked to wait outside, use intercoms, or stand in corridors while unwell, in pain, in labour or concerned about their baby. These experiences were especially distressing during emergencies or at night.

> *“My contraction [kept] coming and my pain level was increasing too much […] I was crying. I was laying down on the floor. I was saying,, can you please offer me a bed? She said, no. At the moment, no. Then I, again, wen*t back outside in the waiting area.” (Woman/birthing person)

Cleanliness, hygiene and infection prevention were serious concerns for some women, birthing people and families. Clean, well-maintained and accessible facilities are part of how safe and dignified care is experienced. Where standards were not met, this affects both physical safety and how people feel about the care environment. For women and birthing people recovering from birth or surgery, poor cleanliness was particularly distressing and could make already difficult experiences feel unsafe or undignified.

> *“[The postnatal ward] was dirty. [My partner] had to bring in, you know, Dettol spray to clean it. There was blood. It was awful. And on another occasion, the baby, like, weed all over my bed and it took me 24 hours to get a clean sheet. In the end, I think I just went to the cupboard and got one and was challenged about doing it […] its was so stressful, I just wanted a clean sheet […] and it took a huge – herculean effort to get one.” (Woman/birthing person)*

Families described toilets and showers that were blood-stained or contaminated with urine, with used pads and urine samples left in bathrooms. They also described mould, insect infestations, and beds or clinical areas that had not been thoroughly cleaned. Shared bathrooms, and too few toilets or showers for large bays, were especially difficult for women experiencing heavy bleeding or recovering from major surgery.

> *“There was blood all around the toilet, and that is how disgusting that hospital is. Underneath the beds, they’re not clean.” (Woman/birthing person)*

The physical environment does not consistently meet the needs of all families

Disabled women and birthing people described maternity and related services where staff lacked disability-specific expertise and there was a lack of accessible equipment and anticipatory planning. Stakeholders representing families also told us that maternity services were often not designed with disabled women in mind.

This had practical consequences. Beds, cots, bathrooms were not always accessible, and hoists were not always available, leaving disabled women and birthing people unable to care for their babies independently and reliant on staff for basic tasks.

Fathers, partners and parents also described environments that did not support them to be present. Where they were allowed to stay overnight, they were sometimes expected to sleep on hard chairs or on the floor.

> *"I ended up sleeping on the floor next to the hospital bed for three nights [...] It made us feel like the NHS felt this was a process that women should endure on their own."* (Family member)

Parents of babies in neonatal units described similar issues. They told us that neonatal estates could make it difficult to stay close to their baby, with not enough chairs by cots, nowhere to rest and poor or limited overnight facilities. These practical limitations affect emotional wellbeing and make it harder for families to remain together.

When things go wrong, environments are not always appropriate

Some parts of maternity and neonatal care require especially sensitive settings. Bereavement care is one of the clearest examples. Where privacy, quiet and protection from the wider hospital environment is not provided, the impact on families can be profound and long-lasting.

Many families described provision that was particularly difficult for bereaved parents, including a lack of dedicated bereavement suites and rooms. Simple elements, such as access to refreshments, were seen as small but meaningful sources of comfort.

Some families described miscarrying or receiving life-changing or devastating news in accident and emergency departments or general waiting areas, which they experienced as deeply traumatic. They also described mortuary locations and routes through hospitals as cold or exposed, requiring them to pass through busy areas.

> *"Can you imagine how I felt having to carry my dead son past all those happy parents with their babies [...] our room should have been in a completely different part of the hospital."* (Family member)

We also saw examples of good practice, where families had been involved in helping to design bereavement spaces, such as at Blackpool Victoria Hospital. We also saw high-quality bereavement facilities at The Queen Elizabeth Hospital, King's Lynn. However, good quality facilities were not consistently available, and we found at least one unit that did not have a dedicated bereavement area.

Neonatal environments can add to stress and safety concerns.

The design and layout of neonatal units can directly affect parental trust and confidence. In settings where parents are already anxious about their baby's health, cramped or poorly designed spaces can add to fear and uncertainty. Parents described, and we observed, crowded cot spaces, with limited room for parents, staff and equipment.

For some parents, this raised concerns about safety as well as comfort. They were concerned that units were too small to manage emergencies safely, worrying that staff or equipment might not be able to reach their baby quickly if something went wrong.

> *"I believe they would not be able to get lifesaving equipment in, both the crash cart, the right set of people into a cot space in the way that the guidelines would say in terms of like time and not like knocking stuff out. I just don't believe that is compliant."* (Family member)

Physical environments affect staff wellbeing and the ability to deliver safe and compassionate care

Staff feedback reinforced many of the issues described by families. Staff described how estate issues affected their ability to provide safe and compassionate care and spoke about the impact on their wellbeing and morale.

Many staff described environments that are not fit for purpose, including outdated buildings, limited space, unreliable equipment and poor maintenance, although in some trusts, staff described recent improvements in specific areas. Limited beds, cots and physical space affected patient flow and increases in activity, such as higher caesarean birth rates, were not always matched by increases in theatre spaces and beds on postnatal wards. Staff reported that space constraints made it harder to manage patient flow safely and provide care that met the needs of women, birthing people and babies from diverse backgrounds.

Poor estate condition also diverted staff time and attention away from care. Where buildings leak, equipment is unreliable or safety hazards have to be managed, staff are required to work around the environment rather than being supported by it. This adds to pressure and can contribute to frustration, fatigue and a sense that basic working conditions are not valued.

> *"Broken beds, faulty doors, cables run across rooms not intended for their designated use, poor ventilation [...] trying to deliver high-quality, safe maternity services with facilities and equipment that are not fit for the task."* (National body representative)

Staff wellbeing was also affected by limited access to adequate rest and break facilities. Staff described small, distant or poorly equipped spaces, including makeshift staff rooms without sinks, water or adequate seating and some staff described having nowhere suitable to rest or eat. Access to rest spaces and opportunities for informal interaction supports staff wellbeing, team cohesion and the ability to deliver safe care. Staff described these rest spaces as particularly important in providing a place to debrief and decompress in high-pressure or emotionally demanding situations. However in many these spaces had been reduced and repurposed when additional space was needed for patient care.

The size and configuration of services shape how environments function

We observed maternity and neonatal units of markedly different sizes and heard evidence that both smaller and larger services present distinct challenges and advantages. This variation also affects how physical environments function in practice, including how space, capacity and staffing pressures are experienced.

Smaller units are able to offer more personalised care, but face difficulties in maintaining workforce resilience, and sustainable senior clinical expertise. Opportunities for clinicians to gain and maintain experience may be reduced where case volumes are lower, particularly when staff are required to provide dual cover for obstetrics and gynaecology.

Conversely, larger units may benefit from broader specialist expertise and greater workforce flexibility, but we were told they can face challenges related to capacity, complexity, and continuity of care. These pressures can affect how care is organised and delivered within the physical environment.

Further work is needed to better understand the relationship between unit size, clinical safety, workforce sustainability, and outcomes for women, birthing people, babies, and families, and to determine the characteristics of services that best support high-quality care.

These issues sit within a wider national context

National reviews have shown that inadequate buildings and ageing hospital estates are a serious challenge for maternity and neonatal services. The Independent Review of Maternity Services in Shrewsbury and Telford in 2022,[106] and CQC's national review of maternity services in England in 2024[107] both found that the condition of hospital buildings can make the care experience more difficult for patients and harder for staff to deliver safely.

Findings from NHSE's maternity and neonatal infrastructure survey[108] indicate that a significant proportion of services are operating in environments that fall short of national standards. A majority of organisations reported not meeting the space requirements set out in HBN 09-02[109] for maternity and HBN 09-03[110] for neonatal services, which set the guidance for the planning and design of maternity and neonatal care buildings in England. These HBNs were first published in 2013 and do not appear to have been updated since then. The maternity and neonatal infrastructure survey also identified widespread challenges relating to storage, estate condition, and compliance with health and safety requirements. Services reported a substantial number of instances where estate limitations disrupted clinical activity or affected patient care.

This points to a mismatch between the design of maternity and neonatal environments and the way care is now delivered. Over this period maternity and neonatal care has become more complex, with changes in clinical need, models of care, and expectations around personalised and family-centred care. Existing guidance does not consistently reflect these developments or fully support the delivery of modern, safe and dignified care.

These challenges are not limited to maternity and neonatal services. In 2024, Lord Darzi's independent investigation of the NHS in England[111] found that the NHS has underinvested in for buildings and equipment for more than ten years. Money intended for long-term improvements has often been used to cover day-to-day costs. The review identified a £37bn gap in capital investment compared with similar countries during the 2010s. It also found that even when funding is available, strict controls and complex approval processes can mean trusts struggle to spend it. As a result, estates problems continue and contribute to wider system failures.

Senior leaders also described system-wide issues with estates, a backlog of maintenance, and significant capital pressures. They did not view maternity and neonatal services as a *"forgotten corner"*, but rather as symptomatic of the wider capital environment of the NHS.

Digital systems are fragmented, which impacts both on safety and families' care

Alongside the physical environment, digital systems are a core part of the infrastructure that supports care. They shape how information is recorded, shared and used by staff, and how confident families feel that important details are known and acted on.

National evidence from the NHSE Digital Maturity Assessment[112] indicates that fragmentation across digital systems is widespread and reflects how services have developed over time. Many maternity and neonatal services use multiple information systems, as a result of local procurements and legacy infrastructure.

> *"They [electronic systems] don't speak. So, for example, on the ward if you're giving a woman medication on [system 1], you've got to also put it on [system 2] [...] and if the woman said "I've not had any pain relief" I then have to audit it. I can't get onto [system 1] if she's been discharged and if the midwife has not put it on [system 2], oh, it opens up Pandora's box."* (Staff member)

Maternity and neonatal services also operate within a mixed landscape of paper-based and digital record systems, with a continued shift towards electronic records. While most services now use digital systems, reliance on paper or hybrid approaches remains common, with around two-thirds of maternity services and 79% of neonatal services continuing to use paper in some form.

Families described the consequences of this fragmentation. They raised concerns about incomplete or inconsistent records and difficulties accessing information when needed. These problems often became visible when something went wrong, with key information not always accessible or available to families or to those providing care.

> *"...it is actually really fundamentally unsafe in my opinion because you basically cannot see what's been documented [...] so you've got no way of monitoring what's going on at all."* (Family member)
>
> *"You're told everything is on the app, but then you look and it's not there, or it appears days later. You don't know what staff can see and what they can't."* (Family member)

When families asked questions after a death or harm has occurred, they were sometimes told the information was *"not in the system"*. This increased confusion and undermined trust. Problems with record quality were also reported, including administrative errors, such as correspondence sent about future appointments, when a baby had died.

Staff had similar concerns. Electronic patient records (EPRs) were not always fit for purpose, with poor interoperability, technical failures, and duplication across multiple platforms. In some cases, staff did not have access to important clinical details because they were held in different systems, in other cases, disconnected systems and platforms increased the time needed to record and access information, reducing time available for direct care. Some staff described having to write on aprons or scraps of paper when systems were not able to keep up with the demands of emergency situations or were not working effectively.

> *"We have to write the birth weight for a baby in five different places and it just -- and then put it on the system as well, and that's purely just duplication of systems."* (Staff member)

Digital documentation was frequently described as taking longer than paper-based systems. Families observed midwives spending significant time on computers and staff recognised it was hard to build a relationship with a family while they were having to input important information into the digital system.

> *"...we have a laptop, which when we go to women's houses, we have to say, "Can we log onto your Wi-Fi please?" So they're there in labour while the bloke is trying to find you the Wi-Fi code so you can log on. You then have to fill in 15 forms before you can start looking after the woman to make sure that she's safe. If you don't do it regularly, that*

> *takes ages. So you're there literally thinking, oh, you just hang on while I fill in all these forms.*" (Staff member)

Administrative and booking systems were also described as unreliable, with reports of missed or duplicate appointments, delayed referrals and confusion about follow-up. Families had to chase care repeatedly.

> *"I was [...] a high-risk pregnancy [...] one of the referrals that was meant to be made was [...] because I needed to be considered for possible cervical cerclage, and I raised [it] on a number of occasions. Things got later and later. It got to my 20 week scan, and again, I raised it, and at this point, they finally found that they'd lost the -referral - because- of the new [electronic note] system, the referral had gone into cyberspace. Then it was all rushed through, and basically it was too late, it was too risky for them to administer a cerclage. The response was "Yes it's really rubbish. We're sorry about that. We had some teething problems bringing in [electronic notes]."* (Woman/birthing person)

A result of this fragmentation is that families are asked to repeat distressing information, including when moving between hospitals or departments.

> *"...the communication between the [different] levels [...] when I had to be transferred between the levels, was [not good]. It seems like there's so many people who are looking after you, but there's not one person who actually knows the story. So you need to repeat and repeat and repeat and repeat. When, after a very bad experience which I've had, it's quite difficult to get everything sorted and explain once again".*
> *(*Woman/birthing person)

One mother described having to explain her medical history again while in labour because key information was not recorded in the paper records used by the team caring for her. Experiences like this left families worried that vital details were being lost.

Digital systems can reinforce inequalities and barriers to care

Poorly designed digital systems can also reinforce inequalities. Where information about language, ethnicity or social factors are not recorded consistently or accurately, it can limit the ability of services to understand whether care is safe and appropriate for everyone.

Families described how digital systems, online forms and portals could create barriers and uncertainty. Some found digital-only processes confusing or inaccessible. This left some families unsure whether key details had been submitted, captured accurately or acted on.

> *"So you don't even have any communication with a person, it's just online [...] So how do you know you've done it right and all of that, and like I said, some people struggle to use the internet and computers and read and write."* (Family member)

Rigid documentation fields that cannot accommodate inclusive language and diverse family structures sometimes led to safeguarding risks being missed, and stressful interactions.

> *"I have seen a midwife try and be really lovely and cross out father and write, you know, mother on that, and then take a family history, including a medical history, from a non-gestational, no reciprocal IVF parent, and do referrals to neonatology for medical issues that were not going to affect that pregnancy. And I have seen the mums be told that if they didn't turn up to that neonatology appointment, they would be recorded as acting against medical advice. So, turning up to the appointment, wasting their time, wasting all of that time. On the other side of it, I've seen midwives correctly take donor's information, have to put it in the father's bit, because it was medically relevant, but then have no space to record the fact that there was coercive control in the lesbian relationship, and therefore not do an appropriate referral for domestic violence."* (Doula)

National evidence shows these are system-wide issues

National investigations have also highlighted how failures in digital systems can contribute to unsafe care. The Independent Review of Maternity Services in Shrewsbury and Telford[113] found that poor flow of information contributed to harm that might have been avoided with better communication. The Independent Investigation on Maternity and Neonatal Services in East Kent,[114] found missed warning signs and lost chances to prevent tragedy.

CQC's national review of maternity services in England[115] also found that poor systems and processes sometimes contributed to delays in emergency care. CQC warned that, if these issues were not addressed, unsafe practice could start to feel normal to staff.

The HSSIB review[116] of patient safety issues associated with electronic patient records found that they could contribute to the risks of aspects of patient care being missed, delayed or incorrect. These risks remain persistent despite national recommendations and actions seeking to mitigate them.

Digital infrastructure has not kept pace with the needs of modern maternity and neonatal care or with wider advances in the use of digital and artificial intelligence (AI) across society. This misalignment represents a major safety risk for our current and future maternity and neonatal services.

We note that the government's 10 Year Health Plan for England,[117] published in 2025, set out the importance of moving from analogue to digital, including the single patient record. This record will bring patient data together in one secure, easy-to-access place, and be accessible across care settings, reducing duplication, closing gaps in information, and supporting safer, faster, more co-ordinated and personalised care. This must deliver for maternity and neonatal services.

Clinical data is used not only to provide direct care, but also to support audit, learning, research, planning and improvement of services. Safety systems, such as the Maternity Outcomes Signal System (MOSS),[118] which has been implemented nationally to analyse routine data and provide early warning of potential safety concerns, rely on timely clinical information being entered correctly. Without good quality data, these systems cannot work as effectively intended and may not enable vital early safety checks and escalation.

Action must be taken to ensure long term capital investment though 12-month, five-year and 10-year plans

Estates and digital infrastructure provide the foundations of safe care, but they have not received the sustained investment required.

Maternity environments should be clean, welcoming, easy to navigate and designed around the provision of safe, personalised and compassionate care. This includes space for families to stay together, which protect privacy, and bereavement suites located away from the main labour wards. There must also be sufficient capacity to meet the demands of today, including operating theatres which are adequately sized and equipped and recovery and high dependency areas which are large enough to care for women and birthing people following planned and emergency caesarean births and other surgical procedures.

In addition, neonatal units should be safe and secure in their design, enable FICare that recognises parents as partners in care, with access to both private rooms and safe spaces.

The planning and design of maternity and neonatal care buildings should facilitate multidisciplinary working and ensure there are appropriate spaces for staff to rest in a service that is high pressured and emotionally challenging.

For maternity and neonatal services to be safe and reliable, digital systems need to be easy to use, work well with each other, record information in a clear and consistent way and provide clear information to families and staff. This includes defining, mandating and collecting clear national datasets, to ensure that every woman and baby has one single, digital record that follows them wherever they receive care. Digital tools, including AI, which have been rolled out in other parts of the health system should be explored, to support the recording of care interactions, such as documenting conversations or routine information.

Conclusion

We must create a modern maternity and neonatal service

The report so far has explored many of the factors that influence the quality and safety of maternity and neonatal care. These have included the importance of listening to women, taking actions to address their concerns, tackling racism and inequalities, strengthening leadership, governance and accountability, and promoting effective teamwork and a positive culture. We have also identified workforce pressures and the challenges posed by outdated physical environments and digital IT systems. Together, these issues highlight that safe and compassionate care depends on much more than individual clinical practice; it relies on well-led organisations, supported staff and systems that work effectively for everyone.

This has led us to the conclusion that the maternity and neonatal system needs urgent reform, putting safety at its centre, and embedding listening to women and anti-racism practice at every level.

We need to move to a maternity system that is designed to meet the needs of women, birthing people and families safely. One that is based on a system design that is constantly learning and responding to real time monitoring data. A system that listens to the women, birthing people and families who use and rely on it. A system that is designed for meeting national standards and reducing local variation. A system that provides continual assessment of safety processes rather than relying on retrospective data. A system that prioritises action and learning.

To drive the system change required and the oversight necessary for implementation, the creation of a statutory national Maternity and Neonatal Commissioner is needed. The legislative framework needed to create the Commissioner role must be included without delay in the Health Bill currently in Parliament.

Statutory Maternity and Neonatal Commissioner

The new statutory role of Maternity and Neonatal Commissioner, accountable to Parliament, will provide the oversight needed to hold the wider system to account in maintaining a relentless focus on improving maternity and neonatal care.

The Commissioner should:

- Co-chair the Maternity and Neonatal Taskforce with the Secretary of State for Health and Social Care.
- Work in partnership with national leaders to support delivery of the Modern Service Framework, ensuring the implementation of safety standards and improving care across the whole pathway. This includes: tackling racism, discrimination and inequality; listening to women and families; and developing a positive culture that

challenges poor and unacceptable behaviour. All of these must be treated as critical safety issues.

- Engage meaningfully with women, birthing people, families, and representative groups to inform priorities and decision-making, and champion approaches to listening to women and families that lead to visible action and change.
- Provide scrutiny of the Department of Health and Social Care and NHS England's work to transform the maternity and neonatal system.
- Engage with leaders in trusts, ICBs and maternity and neonatal services across the country.
- Support coordinated action across the Department of Health and Social Care, NHS England and NHS Trusts, to implement specific recommendations.

More broadly, the Commissioner should provide expert input to national policy developments relating to maternity and neonatal services, informed by evidence, data and lived experience.

The Commissioner should communicate progress, challenges and achievements clearly and transparently to families and to Parliament, reporting directly to the Health and Social Care Select Committee, with a written progress report every six months and an annual statement to Parliament. Reports should set out progress against recommendations, key risks and barriers, action taken to address them, and next steps.

In tandem with the creation of the role of Maternity Commissioner, a Modern Service Framework for maternity and neonatal services must be developed and implemented. Modern Service Frameworks set national standards and define the evidence-based models of care needed to meet them. Crucially, they set implementation timelines and accountability structures to track progress. A Framework for maternity and neonatal services would, for the first time, provide a consciously designed, nationally consistent blueprint for what safe, personalised maternity care should look like, and a clear roadmap and accountability mechanisms for how to get there.

> *"If you don't have a strategy, you don't know where you're going, you don't know what you're trying to do and you don't know how you're going to do it. There isn't a strategy […] for maternal and neonatal care in this country. And therefore, we haven't set out […] what does good look like? […] We haven't set out what the resources are that we require […] there should be a full-scale strategic review […] a modern service framework […] it should look at all of these areas […] what would be a good model of care?"* (Dr Penny Dash, Chair, NHS England)

Specifically, the Framework would establish:

- **Nationally agreed service standards**: covering women, birthing people and family involvement, digital systems, buildings and estates, and more.
- **Clear accountability**: setting out who is responsible for delivering standards, at trust and national level.
- **Consistent implementation expectations**: so that quality of care does not depend on where a woman or birthing person lives.
- **Defined workforce requirements**: including safe staffing levels, skill mix, training expectations, and role standards for advanced-practice midwives and specialist obstetricians.
- **Mandatory standards for triage and Maternity Day Assessment Units (MDAUs)**: including staffing, seniority of cover, physical environment, and response times.
- **Integrated safety and quality measures**: enabling consistent performance monitoring.
- **National oversight of outcomes and inequalities**: with specific accountability for the persistent gaps affecting Black and Asian women, birthing people and those living in the most deprived areas.
- **A unified approach to learning**: ensuring that when things go wrong, lessons are shared and acted on nationally.
- **Better coordination between services**: joining up maternity, neonatal, mental health, GP and community care in a way that does not currently happen consistently.

The Framework must reflect the different needs of local people, allowing for adaptation where this improves access or better meets identified need. It should also be designed with future demand in mind, anticipating how the profile of women and birthing people using services will continue to evolve.

For the first time, maternity and neonatal care in England could have a blueprint: consciously designed with safety, effectiveness, equity and personalised care at its core. A blueprint that creates the conditions for staff to provide the care they are trained to give and for women, birthing people and families to receive the care they deserve.

A modern service that would enable cultural, leadership and governance failures to be addressed. A modern service with zero tolerance of racism and discrimination. A modern service rooted in an NHS which, in the words of the NHS Constitution, ‘belongs to the people’ and which aspires to the highest standards of excellence and professionalism. The foundations are there. With listening at its heart, we have the opportunity to grasp the challenge and create a maternity and neonatal service fit for the future. A service which is accountable and which gives families confidence.

Annex 1: Inclusive language and terminology

Purpose of this annex

Language matters in maternity and neonatal care. It can shape whether people feel recognised, respected and safe, and whether they feel able to ask questions, raise concerns and seek help. It also matters because this report speaks to several audiences at once: women and birthing people, families, bereaved families, staff, policy makers, researchers, regulators and the wider public.

This annex explains the approach to terminology used in the report. It is intended to support clarity, transparency and inclusion, while recognising that language in maternity and neonatal care is complex, evolving and sometimes contested.

Our approach

This report recognises that entirely gender-neutral language which removes the term "women or men" can create communication issues. Therefore, this report uses an additive approach to language. By this, we mean that the report seeks to centre the experiences of women and mothers, while also recognising that not everyone who is pregnant, gives birth, or uses maternity and perinatal services identifies as a woman or mother. The report therefore does not use a single term in all contexts. It uses language according to meaning, evidence source and audience. Terms used across the report include “women”, “mothers”, “women and birthing people”, “parents”, “partners”, “babies” and “families”.

Where the report discusses national data, maternal mortality, clinical evidence or inequalities based on sex, it often uses “women”. This reflects the way much of the evidence base, policy literature and routinely collected data are currently framed, and it allows the report to describe clearly the inequalities and harms experienced by women in maternity care.

Where the report describes lived experience, family involvement, discrimination, access to care or individualised support, it may also use broader terms such as “birthing people”, “parents”, “partners” and “families”. This reflects the diversity of people and families who use maternity and neonatal services, including trans men, non-binary people, LGBTQ+ families, adoptive parents, non-birthing partners and wider family or support networks.

The purpose of this approach is not to replace the language of women and motherhood. It is to add language where needed so that people who may otherwise be overlooked are also recognised.

How this approach was developed

The Investigation considered a broad range of views on terminology discussed by Expert Advisors. In developing the report, we considered current NHS and DHSC language, maternity and neonatal policy, equality and inclusion guidance, clinical terminology, academic evidence and the language used by families and staff who contributed to the Investigation.

The review also heard that people can experience exclusion, discrimination or poorer care in many different ways. This includes discrimination or disadvantage linked to race, ethnicity, faith, language, disability, age, mental health, social circumstances, migration status, sex, gender identity, sexuality or family structure. Inclusive language is therefore not only about gender identity. It is part of a wider commitment to respectful, accessible and equitable care.

Principles used in the report

The report's approach to terminology has been guided by the following principles:

- To use clear and accessible language for a national audience
- To recognise the central importance of women's experiences and sex-based inequalities in maternity care
- To acknowledge that some people who use maternity and perinatal services do not identify as women or mothers
- To avoid language that unnecessarily excludes people or families
- To use broader terms where these are more accurate or inclusive in context
- To reflect the language used in the evidence base without allowing that to limit recognition of people whose experiences may be less visible in existing data
- To ensure that language supports, rather than distracts from, the report's central purpose: improving safety, equity, dignity and outcomes in maternity and neonatal care.

Population language and individualised care

There is an important distinction between language used in a national report and language used in direct care.

At population level, terms such as 'women' and 'mothers' are often necessary to describe evidence, data, inequalities and policy responsibilities clearly. These terms are also meaningful to many people who use maternity services and should not be treated as interchangeable or incidental.

In direct care, however, language should be personalised. Staff should use the name, pronouns and terms that an individual uses for themselves. Services should recognise different family structures and should not require people to repeatedly explain, justify or correct assumptions about who they are, who their partner is, or who is important to their care.

This is not simply a matter of courtesy. Being misrecognised, dismissed or treated as unusual or ‘too complex’ can affect trust, communication, help seeking and safety. Inclusive language should therefore be understood as part of safe, compassionate and personalised care.

Limitations

We acknowledge the limitations of any approach to terminology. Language evolves over time, and different people and communities may reasonably prefer different terms. Some readers may feel that the report should have used more gender specific language throughout. Others may feel that it should have used more consistently gender inclusive language.

The Investigation has not sought to resolve all wider debates about language. Instead, it has sought to use terminology that is clear, proportionate to the purpose of the report, grounded in the evidence reviewed and respectful of the diversity of people and families who use maternity and neonatal services.

We also recognise that inclusive language alone is not sufficient. Respectful terminology must be matched by accessible services, good interpretation, cultural safety, disability inclusion, trauma informed care, LGBTQ+ inclusion, meaningful family involvement and systems that respond to people’s needs in practice.

Implications for implementation

The DHSC/NHSE may wish to consider these issues further during implementation of the recommendations. This should include working with women and birthing people, parents, families, staff and communities to develop practical approaches to language that are clear, inclusive and usable in real world services.

Implementation should avoid treating inclusive language as a standalone communications exercise. It should be considered alongside wider work on respectful care, interpretation, accessibility, cultural safety, disability inclusion, LGBTQ+ inclusion, family involvement, trauma informed care and staff training.

The aim should not be perfect terminology for every possible context. The aim should be better care: care in which every woman, parent, baby and family is treated with dignity, listened to, and able to access safe, compassionate and equitable support.

Annex 2: Methodology – how the Investigation conducted its work

Overview of the Investigation

The then Secretary of State for Health and Social Care, the Right Honourable Wes Streeting MP, commissioned a National Independent Investigation into Maternity and Neonatal Care in June 2025, in order to help bereaved and harmed families to receive justice and accountability in the future and to identify and address systemic problems that had led to failings in care. This decision followed a series of meetings between the Secretary of State and bereaved and harmed families. The Secretary of State also committed to establish and chair a National Maternity and Neonatal Taskforce, to be made up of a panel of experts and bereaved and harmed families to implement the eventual recommendations of the Investigation.

Baroness Valerie Amos was appointed Chair of the Investigation on 14 August 2025, following consultation with families.

The Investigation's Terms of Reference[119] were published on gov.uk on 15 September 2025, having been agreed by both Baroness Amos and the Secretary of State. Families were also consulted on the Terms of Reference prior to publication. The Terms of Reference outlined the key aims of the Investigation, which were to:

- Develop and publish one set of national recommendations to:
    a. Drive the improvements needed to ensure high-quality and safe maternity and neonatal care across England
    b. Reduce inequalities and promote health equity in the delivery of those services
    c. Help bereaved and harmed families to receive justice and accountability in the future.
- Ensure that the lived experiences of women, babies and families, including fathers and non-birthing partners, were fully heard and used to inform the development of the national recommendations.
- Conduct and publish 14 (later reduced to 12 – see below) local investigations of maternity and neonatal services in NHS trusts and use these, alongside other sources of data and evidence gathered by the Investigation, to inform the development of the national recommendations.

Families were also consulted on the appointment of a group of Expert Advisors to support the Investigation. The appointment of two Expert Advisors was confirmed in August 2025, followed by an additional six in October 2025 and four in March 2026. The Expert Advisors represented a range of professions – midwives, obstetricians, neonatologists, in addition to experts in public health, investigations and anaesthesiology.

Approach to conducting the Investigation

From the outset, the Investigation adopted a ‘Families First’ approach, meaning that women, babies, families, including fathers and non-birthing partners, were placed at the heart of the Investigation. ‘Families First’ has been adopted by a number of previous national reviews and investigations, including the Hillsborough Inquiry and the East Kent Review of Maternity Services. Family engagement was therefore a fundamental part of the Investigation process. However, individual case reviews were not within the scope of this Investigation.

The independence of the Investigation was considered essential to give families confidence that it would not be constrained in how it conducted its work. In addition to the independence of the Chair and Expert Advisors, all members of the Investigation team were required to sign a declaration of interest form.

The draft methodology was published on the Investigation website on 10 December 2025.

How trusts were selected for local investigations

In selecting trusts to investigate, the Investigation aimed to ensure that findings would be relevant across the system. Trusts were therefore chosen to reflect a variation in trust type e.g. large tertiary teaching trusts and small rural district general hospitals, geographic and demographic coverage, in addition to selecting three trusts that had been subject to previous investigations. Family feedback was also taken into consideration when selecting trusts to investigate.

An initial list of 14 trusts was selected for investigation. However, on 24 October 2025, the Chair announced that two trusts were being removed from the scope of the Investigation: Leeds Teaching Hospitals NHS Trust was removed following the Secretary of State’s announcement on 20 October 2025 that he would be commissioning an independent review into the Trust’s maternity units; and Shrewsbury and Telford Hospital NHS Trust was removed following discussions with West Mercia Police about the detail and schedule of their ongoing criminal investigation.

The final list of NHS trusts in scope for investigation was as follows:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- East Kent Hospitals NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust

- Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- Somerset NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- University Hospitals Sussex NHS Foundation Trust.

The methodology used when visiting these trusts is set out alongside the local trust reports.

Approach to risk/escalations

The Investigation had a clear escalation protocol in place for addressing serious concerns and risks to patients and staff. When immediate risks which posed a potential risk to patient safety were identified, the Investigation team notified the Chief Executive of the trust and/or medical/nursing Director and NHSE. During the course of its work, the Investigation made a number of escalations using this protocol.

Ethical approach/data governance

The Investigation’s privacy notice was published on its website, outlining its policy for data collection and processing in line with Articles 6 and 9 of the United Kingdom General Data Protection Regulations (UK GDPR). This included the organisations involved in the processing of data, including external suppliers, and was updated as the Investigation progressed.

How we worked with families

As noted above, the Investigation adopted a ‘Families First’ approach in carrying out its work. This included ensuring that public announcements and final copies of all reports written by the Investigation were shared with families first, prior to publication. The Investigation published its Family Engagement Strategy[120] on the Investigation’s website on 10 December 2025.

Family evidence panels

Family evidence panels were conducted as part of the local investigations, with at least two panels held for each NHS trust. Family evidence panels were started before any other activity relating to the trust site visit took place, at a venue away from the hospital site. In order to maximise participation from affected families, and, if necessary to ensure representation of sufficient breadth of experiences, the Investigation held additional evidence panels with families from specific trusts after the conclusion of the wider programme of site visits had concluded, the majority of which took place remotely. Overall, 40 family evidence panels relating to the 12 trusts were conducted, attended by 323 affected families.

The Investigation also held family evidence panels outside of the local investigations as part of its wider review of the maternity and neonatal system. The Investigation's engagement with families had a particular focus on ensuring diverse voices were heard, including seldom-heard groups and those experiencing health inequalities and inequities. The Investigation arranged a number of engagement panels specifically for this purpose. The Investigation also arranged evidence panels to gather family feedback on its work reviewing previous maternity and neonatal recommendations.

When seeking participants for its family evidence panels, the Investigation support team made contact with a range of organisations and individuals, including:

- Maternity and Neonatal Voice Partnerships
- Maternity and Neonatal Independent Senior Advocates, where the trust's ICB had been part of this pilot
- Bereaved or harmed families or family groups who were in contact with the Investigation
- Voluntary and community groups
- Local MPs.

An information pack was shared with families ahead of any meetings or engagements. This included the themes to be discussed in the meeting or engagement, in addition to information on:

- Emotional and psychological support
- Values and behaviours in meetings
- Remuneration for time and expenses
- Investigation protocols such as privacy notice, safeguarding and complaints
- Frequently asked questions.

Families were asked about any accessibility requirements they had ahead of meetings and engagements. Families were also asked to complete a participation form to confirm their attendance which included providing their contact details, and to confirm they had read the information provided. Families were compensated for their expenses and were also given the option to opt-in to receive remuneration for participating in meetings and engagements.

Interviews

Bereaved and harmed families also had the option to give evidence through a one to one interview with one of the Chair, an Expert Advisor, or a trained interviewer within the Investigation support team. In total, over 90 interviews with bereaved and harmed families were conducted.

Call for Evidence

The Investigation conducted a Call for Evidence[121] for eight weeks between 20 January 2026 and 17 March 2026. The Call for Evidence consisted of two surveys: one for women who had been pregnant to share their own experiences of maternity and neonatal services and one for other people to share their experiences supporting someone through pregnancy, including fathers, non-birthing partners, family members, friends and other support people. Families were consulted on the design of the Call for Evidence. The Investigation received over 10,000 responses from women, birthing people and families across both surveys.

EasyRead versions of both surveys were available and people who could not access the online surveys were able to request a printable version. The surveys were also available in braille and translated into seven additional languages: Arabic, Bengali, Gujarati, Polish, Punjabi, Romanian and Urdu. For people who needed support to share their experiences in other languages, the Investigation offered one-to-one interviews with an interpreter. Evidence could also be submitted by video in British Sign Language and individual interviews with a British Sign Language interpreter were available.

In addition, families provided written evidence to the Investigation email inbox (including, in some cases but not limited to, first hand experiences, complaint letters, reports, research papers, charity submissions, and photographs).

How we worked with staff

Site visits were conducted at each of the 12 NHS trusts. Initial site visits commenced in November 2025 and concluded at the end of January 2026. The Investigation team also carried out a small number of return visits to some sites, in order to conduct further evidence gathering interviews and panels, as well as allowing Expert Advisors with specific areas of experience and expertise to visit the sites. These additional visits were concluded by the end of February 2026.

Staff evidence panels

Staff evidence panels were held on site at each of the 12 NHS trusts to hear the experience of a range of staff delivering maternity and neonatal services. The Investigation liaised with key contact points at each trust and asked staff who wanted to participate in the evidence panels to complete a consent form. Information on data sharing and how panels would be conducted was shared with participants via email.

Interviews

Interviews were conducted with:

- Labour ward coordinators
- Neonatal ward managers
- The Executive Team of each trust, including trust board members and senior managers.

Workforce survey

The Investigation also conducted an online workforce survey, which was open from 26 January 2026 until 9 March 2026. The survey was open to all staff working in maternity and neonatal care across England and was separate to the public Call for Evidence, which was only open to women, families and people who had supported someone through pregnancy. The workforce survey focused on the experiences of staff delivering care across the maternity and neonatal pathway and how best to support teams to provide high-quality, safe and compassionate care. The Investigation received over 9,000 responses to the workforce survey.

Information about how to access the workforce survey was distributed to all NHS trusts, who were asked to cascade the link to all maternity and neonatal staff groups (clinical and non-clinical, substantive and bank) via usual internal channels (e.g. bulletins, intranet, team leads).

Other forms of evidence from staff

The investigation also received written evidence to the Investigation email inbox from current and former staff (including, in some cases but not limited to first hand experiences, resignation letters, and reports).

How we engaged with national system leaders and national and regional organisations

The Investigation also engaged with a wide range of organisations and individuals as part of its systemwide review of evidence.

Evidence panels

Evidence panels were held with national and regional maternity and neonatal leaders, professional member organisations and ICBs (a full list is provided at Annex 5). Additional evidence panels were organised for the Investigation by a number of All-Party Parliamentary Groups (APPGs) with an interest in maternity and neonatal care.

Interviews with national system leaders

The Investigation interviewed a range of national leaders who interact with the healthcare system, including representatives from national regulatory and investigatory bodies, government departments, Royal Colleges and other key organisations (full details at Annex 5).

The focus areas and interview questions used during these interviews were informed by evidence collected from families and staff during the Investigation.

Written evidence

In addition to the evidence panels and interviews, the Investigation requested written evidence from a variety of individuals and organisations (see Annex 5).

Evidence Management

Interviews and evidence panels were transcribed. Family transcripts were anonymised to protect the privacy of people sharing their personal experiences. To ensure its findings were accurate and fair, the Investigation followed a strict quality assurance process for all evidence, including documents and transcripts. Every transcript was carefully checked by members of the Investigation team and interview transcripts were shared with interviewees. This ensured that transcripts were a true and accurate reflection of what was said. As part of this process, the Investigation shared transcripts with the people interviewed so they could review their words and confirm the accuracy of the record.

Analytical methods

Once the evidence was confirmed, the Investigation used a systematic approach to understand the results. The Investigation started with thematic analysis, which meant looking for common patterns or recurring issues in the accounts people gave us. The Investigation then used triangulation to double-check these findings. This involved comparing different sources of evidence to identify the areas where the evidence was most consistent and compelling.

The reported findings were identified by looking at the problems within the maternity and neonatal system. In this context, a ‘system’ refers to the entire network of people, processes and resources that work together, including frontline clinical staff, management, hospital policies, the physical equipment used and the space where the care was delivered, as well as the external organisations that influence how care can be delivered.

The final stage was the synthesis of findings, which brought all these different elements together to form a complete picture. By looking at the ‘big picture’, the Investigation was able to identify systemic issues and decide on the best recommendations to make the service safer for patients and their families.

This approach helped the Investigation to pursue an evidence-based approach, focusing on the specific issues where the weight of evidence showed where urgent change was needed.

Use of AI

The Investigation collected an unprecedented amount of evidence in a short space of time, including transcripts of interviews and evidence panels and over 10,500 submissions to the public Call for Evidence. Manually analysing this evidence in detail would have taken more than a year, even for a large team, and so would not have been in line with the rapid review commissioned by the Secretary of State.

After testing a range of options, including topic modelling and enhanced manual approaches using specialist software, the Investigation concluded that a carefully controlled, AI assisted approach would be the best way to ensure that every piece of evidence could inform its final recommendations within the timescales. The analysis used an inductive, descriptive form of thematic analysis following Braun and Clarke's six-phase framework, leveraging the capabilities of Large Language Models to analyse large volumes of data at speed while thematic development and quality checks remained analyst led.[122]

The Investigation was aware that using AI to analyse people's lived experiences could raise concerns. Great care was taken to understand when AI could be used safely and responsibly, and how it could help the Investigation to hear from as many people as possible, as quickly as possible.

AI was used as a tool to support human analysts, not to replace their judgement. No AI tool made findings or reached conclusions on behalf of the Investigation. To use AI safely, the Investigation combined the latest research with the expertise of qualitative researchers and data scientists. The method followed the same steps a human team would take, but used AI to speed up the process, while ensuring that expert analysts remained in control at every stage.

The Investigation's analytical approach was designed to examine the data in depth, not simply to produce a high-level summary, and included regular checkpoints where human analysts reviewed and quality assured the AI assisted outputs.

Limitations

The Investigation concluded within 10 months of the publication of its Terms of Reference. This was shorter than many previous local reviews of maternity and neonatal services, which, in some cases, lasted several years. The Secretary of State deliberately commissioned the Investigation as a rapid review in order to deliver change and improve outcomes for women and families as quickly as possible.

As outlined above, the Investigation heard from a significant number of families, staff and other stakeholders. There are limitations to each method of data collection - interviews, panels, surveys, written submissions - which may influence the nature of the evidence received, but the Investigation has collected data via multiple methods as a way of addressing this. However, given the time-limited nature of the review, it was not possible to speak to every single person or organisation who may have had information to share with the Investigation. The conclusions and recommendations of the Investigation therefore depended on the accuracy and completeness of the evidence it received. The large number of views and experiences incorporated into this review give confidence that its findings apply more widely.

The Investigation did not review clinical notes or full patient records, and its final report is therefore not a detailed review of individual clinical care, nor a reassessment of treatment decisions.

The Investigation's aim has been to deliver a set of national recommendations which will help to ensure every woman and baby receives safe, high-quality and compassionate care. In publishing the Investigation's final report and recommendations, the Chair and her Expert Advisors are confident that this aim has been met. However, the report should be read with the limitations outlined above in mind.

Publications

The Chair's Reflections and Initial Impressions were published on the Investigation's website on 9 December 2025.

The draft Methodology and Family Engagement Strategy were published on the Investigation's website on 10 December 2025.

The Interim Report was published on the Investigation's website on 26 February 2026.

The Final Report was published on the Investigation's website on 30 June 2026.

Annex 3: A rapid review of previous recommendations for maternity and neonatal care

Introduction

The Investigation undertook a review of previous recommendations in maternity and neonatal care. This included a thematic review of previous recommendations, alongside an examination of their implementation and impact.

Successive investigations, reviews and national programmes have generated a substantial number of recommendations for maternity and neonatal care. However, as reflected in the commissioning of this Investigation, this has not consistently translated into sustained improvements in the everyday delivery of care.

This review focuses both on what has been recommended, and how recommendations have been taken forward in practice. It considers the extent to which recommendations have been implemented, embedded and sustained over time, and what this indicates about current approaches to improvement.

The findings of this review not only describe the current landscape but also provide insight into how recommendations can be designed more effectively in future and has thereby informed the development of recommendations from this Investigation.

Part 1: Implications for developing future recommendations

A consistent set of themes emerged as part of the review of previous recommendations. These include the high volume and duplication of recommendations, limited clarity on ownership and accountability, and the difficulty of embedding and sustaining change over time.

This suggests that the effectiveness of recommendations depends not only on what is recommended but on how recommendations are designed.

Table 1 sets out a series of core design principles to guide the development of future maternity and neonatal recommendations arising from this Investigation. These principles are not themselves recommendations and they do not prescribe specific service models, delivery approaches or regulatory requirements. Instead, they draw together consistent findings from this review about why previous recommendations have not always led to sustained improvement.

In particular, the evidence shows how these challenges relate to issues of feasibility, alignment across the system, and the practical conditions required for implementation.

The principles are intended to support the development of recommendations that are clearer, more proportionate and more workable in practice, while allowing flexibility in how they are implemented across national, regional and local contexts.

Table 1. Core design principles for future recommendations

Principle	What this means in practice
1. **Fewer, clearer, prioritised recommendations: Evidence highlights that the current landscape is experienced as a 'sea of recommendations', creating confusion and diluting focus.**	• Limit the number of recommendations • Prioritise what matters most • Focus on a smaller number of high-impact priorities
2. **Reduce duplication and support consolidation: Recommendations have often been added to, rather than replacing or consolidating existing expectations.**	Consider: • Consolidating related recommendations into clear areas of action • Reviewing or retiring outdated recommendations • Aligning to a coherent set of system-wide requirements
3. **Explicit ownership and accountability: Previous recommendations often lack clarity around responsibility.**	Each recommendation should clearly state: • Who owns delivery (national, system, provider) • Who is accountable for progress • Responsibility should be shared appropriately across levels of the system, but accountability for delivery should be clearly defined and assigned
4. **Clear, specific and measurable: High-level or ambiguous recommendations are harder to implement and monitor.**	• Define what needs to change in practice to achieve beneficial outcomes, and a clear description of what successful implementation looks like

Principle	What this means in practice
	• Include equitable measures of activity and change • Specify expected timescales for implementation and review • Enable meaningful assurance to all stakeholders • Clarity, measurement and ownership should be considered together to ensure recommendations can be acted on and assessed • Include consideration of equity in both design and measurement
5. **Framed as operational requirements, not just statements of intent: Previous recommendations have often remained high-level or advisory, limiting implementation.**	• Where possible, recommendations should be expressed as clear, operational requirements or expectations.
6. **Designed for real system capacity: Implementation is often constrained by workforce, infrastructure and resources.**	Recommendations should: • Be realistic about deliverability • Set out key dependencies (e.g. staffing, data) • Implementation capacity should be treated as a system design issue
7. **Reflect shared system responsibility: Most recommendations have historically been directed at trusts, even where issues are systemic.**	Recommendations should reflect the contribution required from national, regional and local organisations, including where delivery depends on policy, funding, workforce, data or infrastructure decisions.

These principles point to the need for a more focused and structured approach to putting recommendations into practice. This includes greater emphasis on prioritisation, clarity of ownership, and designing implementation in a way that reflects the realities of system capacity, supports sustained change over time and systematically addresses inequalities from the outset.

The following parts provide the basis for these principles, including analysis of the volume and focus of existing recommendations, and how they have been implemented in practice.

Part 2: Overview of existing recommendations

This part describes the body of previous recommendations in maternity and neonatal care, including their volume, focus and distribution over time.

Recommendations included in this review were drawn from the National Maternity and Neonatal Recommendations Register[123] (as of 22 January 2026), as well as from the Morecambe Bay Investigation,[124] the Independent Review of Shrewsbury and Telford[125], the Independent Investigation into East Kent,[126] and a subset of recommendations from the Neonatal Critical Care Service Specification.[127] A list of the recommendations included has been published alongside this report in the Supplementary Evidence Previous Recommendations document.

These sources were selected, with input from the Expert Advisors to the Investigation, to reflect a focused but influential subset of the wider maternity and neonatal recommendation landscape. They align with the Terms of Reference for the Investigation, which set out a review of recommendations arising from public inquiries and national investigations since 2015. They capture different types of recommendations that shape expectations across the system, including high-profile investigation findings, nationally driven service reform, and clinical and operational requirements.

Number of recommendations

A total of 895 distinct recommendations were identified, spanning the period 2014 to 2025. We extended the review period to 2014 to align with recommendations on the National Maternity and Neonatal Recommendations Register.[128]

These recommendations demonstrate the scale of guidance issued to maternity and neonatal services over the past decade.

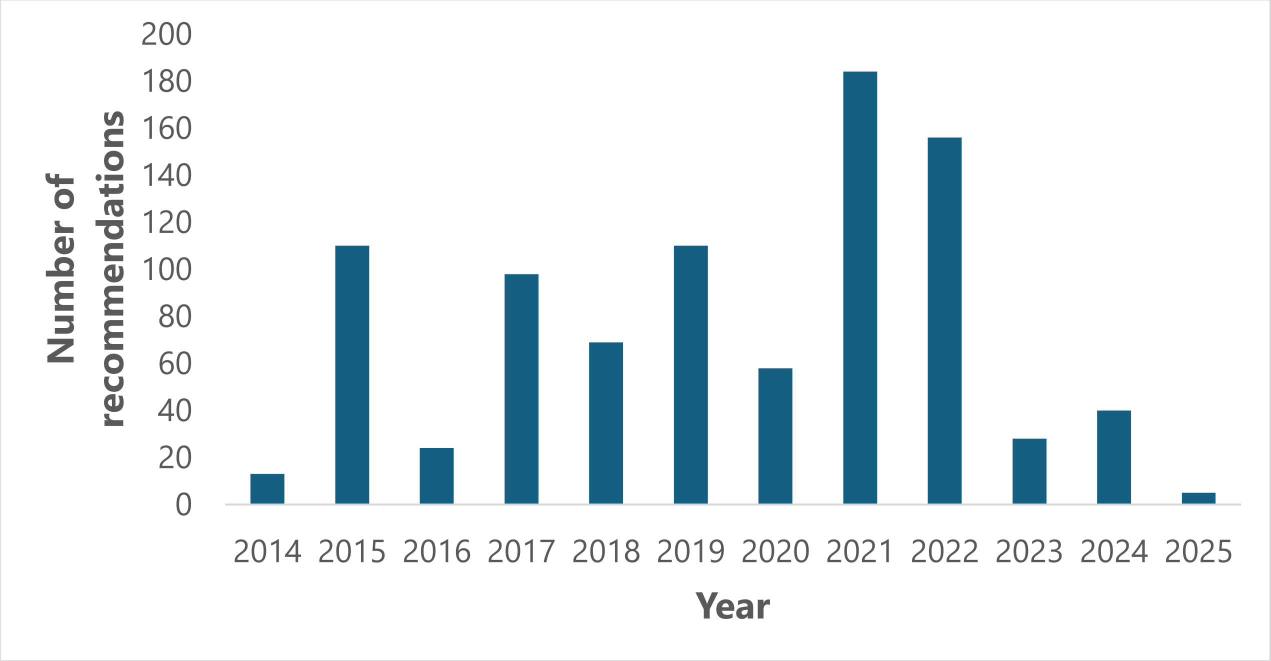
Table 2. Number of recommendations reviewed, by source

Source	Number of recommendations
National Maternity and Neonatal Recommendations Register	741
The Morecambe Bay Investigation	26
The Independent Review of Shrewsbury and Telford	101
The Independent Investigation into East Kent	4
Neonatal Critical Care Service Specification	23

The number of recommendations issued each year varied across the period. A marked increase is visible between 2020 and 2022, coinciding with the publication of the Independent Review of Shrewsbury and Telford[129] and the Independent Investigation into East Kent[130] reports. The highest number of recommendations was recorded in 2021 (184), followed by 2022 (156). The number of recommendations recorded in subsequent years is lower.

This pattern may reflect both changes in how often the National Maternity and Neonatal Recommendations Register[131] has been updated, as well as a shift from a period of intense review towards consolidating existing guidance, such as through the 'Three-year delivery plan for maternity and neonatal care services'[132] in 2023.

Figure 1. Number of recommendations made each year between 2014 and 2025



Focus of previous recommendations

The 895 recommendations were grouped into categories to identify the main areas of focus. As individual recommendations often address more than one issue, they were counted across multiple categories.

Table 3. Recommendations reviewed, by category

Category	Clinical	Investigation-based	Operational	Strategic	Sum of recommendations
Training, skills and guidelines	192	33	205	71	501
Medical pathways, procedures and treatments	228	0	201	52	481

The analysis shows that recommendations have been concentrated in certain areas.

The greater number relate to:

- Training, skills and guidelines (501 recommendations)
- Medical pathways, procedures and treatments (481 recommendations).

Substantial numbers of recommendations also focus on:

- Governance, safety and risk management (364 recommendations)
- Maternity outcomes (281 recommendations).

In contrast, fewer recommendations address:

- Service user experience (108 recommendations)
- Supporting staff (83 recommendations)
- Health inequalities and access to care (63 recommendations).

Very small numbers relate to:

- Teamworking (16 recommendations)
- Estates (3 recommendations)

This distribution indicates that previous recommendations have focussed primarily on clinical practice, processes and governance, with comparatively less emphasis on organisational conditions such as teamworking, infrastructure and physical environment. This imbalance is notable given that both multidisciplinary teamworking and a safe physical environment are frequently identified as critical enablers of safe care.

Type and intended audience of recommendations

Most recommendations were operational (325) or clinical (294) in nature, with fewer focused on strategic change (145).

Most recommendations were directed at provider-level organisations with the majority aimed at NHS trusts (692 recommendations)

A smaller proportion were directed at system-level organisations such as Integrated Care Bodies (ICBs) or Local Maternity and Neonatal System (LMNS) (147 recommendations). Fewer recommendations were directed to primary care (89 recommendations) and DHSC and NHSE (90 recommendations).

A number of recommendations were addressed to multiple audiences and so these numbers are not mutually exclusive.

This suggests that responsibility for implementation of recommendations has largely been assigned at local level, including those related to issues that may reflect wider system constraints.

Changes in emphasis over time

The focus of recommendations has evolved over the review period.

Earlier recommendations, particularly those made in the mid-2010s, tended to address more discrete clinical issues with defined technical responses. For example, recommendations relating to the use of specific interventions to reduce stillbirth or neonatal harm.

More recent recommendations increasingly address wider system challenges, including organisational culture, leadership, workforce behaviours and inequalities in access and outcomes, alongside greater emphasis on engagement with women, birthing people and families, compassionate care and addressing bias and discrimination.

This shift suggests growing recognition that improving maternity and neonatal outcomes requires addressing both technical and organisational factors, alongside a stronger focus on equity and the experiences of women and families.

What women, birthing people, families and service user representatives told us

We shared the findings above with families and service user voice (SUV) representatives to understand their perspectives on them.

Families and SUV representatives consistently perceived the volume of previous recommendations as overwhelming and unmanageable. They felt that the accumulation of hundreds of recommendations over time was likely to contribute to confusion, rather than clarity.

> *"We've kind of got this sea of recommendations"* (Family member)

They questioned how services could realistically respond to such a large number of recommendations, particularly where recommendations appear similar to those made previously.

From their perspective, this creates a pattern where new recommendations are issued in response to harm, rather than a focus on ensuring that existing recommendations are consistently delivered in practice. Questions were also raised about why recommendations are repeatedly restated rather than reviewed, consolidated or formally retired.

Families and SUV representatives generally recognised that many of the recommendations appear reasonable in principle. However, they questioned whether they address the underlying causes of recurring problems. Many recommendations were seen as focusing on what services should do in principle, rather than on how care is experienced in practice. In particular, process driven recommendations were considered insufficient where issues relate to staff culture, communication and leadership.

> *"A lot of them [recommendations] are tinkering around the edges [...] not really responding to root causes."* (Service user voice representative)
>
> *"Almost all of the issues [...] come back to organisational cultures and behaviours."* (Family member)

A recurring emphasis was that improving processes alone is unlikely to lead to meaningful change if staff are not supported, resourced, or able to act differently in practice.

There was also a concern about the limited focus on teamworking. Maternity services in particular were described as often working in siloed ways, in comparison to other areas of healthcare, where multidisciplinary teamworking and shared decision-making are more embedded. Families also highlighted gaps in how services work together across organisational and service boundaries. Where coordination is weak, care can feel fragmented, particularly for women and birthing people with complex needs, with no clear ownership. The limited emphasis on these issues in previous recommendations was seen as a significant gap.

Finally, families and SUV representatives noted that recommendations often focus on preventing immediate clinical harm but place less emphasis on how services should respond when harm has occurred, including longer-term physical and psychological impacts. There was also a feeling that listening to women is insufficiently reflected in the recommendations.

> *"The long-term implications are missing […] these feel very short, sharp, the here and now."* (Family member)
>
> *"All these reports tell us […] we don't listen to women […] not one of these recommendations uses the word 'listen'"* (Service user voice representative)

What we heard from staff and system leaders

Staff and system leaders consistently described the landscape of previous recommendations as extensive, overlapping and challenging to navigate. Across multiple evidence sources they referred to a high volume of recommendations arising from repeated national reviews and inquiries. Accumulation was described as additive over time, with new recommendations layered onto existing ones rather than replacing them, contributing to a crowded and complex improvement landscape.

> *"You barely have one set of recommendations before the next"* (Integrated Care Board representative)

This pattern was frequently interpreted by staff as indicating that earlier recommendations had not been fully implemented or sustained in practice. Evidence from national panels and workforce feedback describes repeated cycles of reviews and action plans with limited impact, with recommendations often *"not sticking"* in the absence of sufficient staffing, time or system support.

> *"There was an action plan around with the LMNS on all sorts of things from previous reports [...] and it's got 400 actions on. And I remember saying, I think nearly falling off my seat and going, I'm not the most academic and brilliant person ever, but I've done a few action plans and you can never deliver on 400 actions. And everybody sort of breathed a sigh of relief."* (Integrated Care Board representative)

Staff accounts also reflected a sense of frustration and fatigue associated with this pattern. Workforce evidence in particular highlights *"investigation fatigue"* and a perception that repeated inquiries have not resulted in meaningful or sustained change, as well as creating feelings of fear and mistrust with the public.

> *"These recommendations are not then aligning properly [...] we're putting demand on the services and providers in a way which is unhelpful. So I think there is a need for greater coordination between these national bodies and bringing things together."* (Dr Arun Chopra, Interim Chief Executive, Care Quality Commission)

Part 3: Implementation and impact of previous recommendations

This part considers how previous recommendations have been taken forward in practice, and what can be observed about their implementation over time.

Implementation of recommendations in maternity and neonatal care does not usually take place as a single, discrete action. Instead, recommendations are progressed through a range of overlapping improvement programmes, assurance processes and governance arrangements at local, regional and national levels.

It is also important to recognise that implementation is a long-term process. Recommendations must not only be implemented but embedded and sustained in practice over time to influence care.

Many of the recommendations reviewed—particularly those from the Independent Review of Shrewsbury and Telford[133] and the Independent Investigation into East Kent [134] are relatively recent. As a result, there is limited evidence available on their impact on outcomes. It is also important to recognise that because there are so many overlapping recommendations and national programmes in place, it is difficult to say with certainty which improvements are due to any one recommendation.

This part therefore focuses primarily on observable changes in systems, behaviours and capabilities, rather than attributing changes directly to individual recommendations.

Understanding implementation in practice

To understand how recommendations are implemented over time, the Investigation examined three major maternity and neonatal investigations and how their recommendations were taken forward in practice.

These investigations provide insight into how recommendations are interpreted, acted upon and sustained in different contexts. The Investigation reviewed documentation submitted by the trusts which were part of the current Investigation, and publicly available records. This included assessments produced by the Thirlwall Inquiry[135] on the implementation status of recommendations made by the investigations.

The Morecambe Bay Investigation

The Morecambe Bay Investigation,[136] published in 2015 and chaired by Dr Bill Kirkup, identified serious failures in maternity care and made 44 recommendations (18 directed at the local NHS Trust and 26 at national bodies). The recommendations focused on restoring basic standards of safe care, including workforce capability, governance, incident reporting, teamworking and organisational culture.

At a local level, the initial response was rapid. Within a year, the Trust reported that all 18 local recommendations had been completed. Actions included changes in senior leadership, strengthened governance arrangements, improvements in incident reporting systems, and clearer processes for escalating safety concerns.

This period was associated with improved regulatory assessments. By 2016, CQC reported improvements in leadership, openness and staff morale, and the Trust exited special measures.

At a national level, the investigation also contributed to wider changes in maternity safety. These included reforms to professional supervision and patient safety investigation processes, as well as increased national focus on maternity safety through programmes such as the Maternity Transformation Programme.[137]

However, maintaining these improvements over time proved more challenging. Subsequent inspections and reviews identified renewed pressures, particularly relating to staffing stability, risk management and the effectiveness of governance systems. The most recent CQC assessments in 2025 show maternity services as good for the first time since 2017.

> *"You know, I got a bit upset the other day when people were saying that it had taken 10 years to make a difference there. It really didn't. It was absolutely turned around, largely due to two people, the chief exec and the head of midwifery, both of whom went on to greater things. Thereby hangs a tale, because when they left, the improvement was not sustained; it went back over. But while they were there, for a few years, it was a real shining light and they did really well."* (Dr Bill Kirkup, Chair of

the Morecambe Bay Investigation and Independent Investigation into East Kent)

Overall, the Morecambe Bay case shows that significant improvements can be delivered quickly following an investigation, particularly where there is strong leadership and external oversight. It also highlights the difficulty of sustaining these changes over time, particularly once the intensity of oversight and scrutiny reduces.

Independent Review of Shrewsbury and Telford

The Independent Review of Shrewsbury and Telford, which was chaired by Donna Ockenden, published an interim report in 2020 and a final report in 2022. It identified widespread failures in maternity care over an extended period and made 84 recommendations (some of which were further broken down into sub-recommendations), including immediate and essential actions to address urgent safety concerns.[138]

The recommendations covered a broad range of issues, including workforce capacity, clinical practice, governance, leadership, multidisciplinary training and engagement with families. The recommendations were highly structured and were accompanied by a strong national focus on assurance.

The initial response was extensive at both national and local level. NHSE introduced a national assessment process[139] requiring all maternity providers to review themselves against the immediate and essential actions and report progress through trust boards and LMNS. Locally, the Trust established dedicated governance arrangements and an action plan to oversee delivery. There is evidence of substantial implementation activity across a range of areas including governance, training and workforce.

These actions were supported by national programmes, such as the Three-Year Delivery Plan,[140] supporting implementation beyond the local trust across the wider system.

At the Trust level, external oversight and support remained in place over several years, with measures such as the Maternity Safety Support Programme[141] only recently withdrawn following the Trust's exit from special measures in March 2026. This indicates that delivery has required sustained intervention over time rather than short-term change. Following its most recent inspection in 2023, the CQC rated the Trust's maternity services as 'Good' overall[142] (2024 report).

While substantial progress has been made, delivery is still ongoing in some areas. Some elements are dependent on national bodies or wider system change, reflecting the scale and complexity of the recommendations and the reliance on national policy, funding and programme support for delivery.

In particular, culture, leadership behaviour and listening to women, birthing people and families remain a focus of national improvement activity, oversight and evaluation. Evidence suggests these areas are not yet consistently embedded across services and continue to require sustained attention over time.

Overall, the Independent Review of Shrewsbury and Telford[143] shows that large-scale, nationally coordinated implementation can deliver extensive action where there is focus, resource and oversight. It also highlights the scale and duration of effort required to deliver and sustain change, particularly where improvements depend on workforce capacity, leadership continuity and cultural change, and where delivery relies on national policy, funding and system-level programmes as well as local action.

The Independent Investigation into East Kent

The Independent Investigation into East Kent,[144] published in 2022 and chaired by Dr Bill Kirkup, identified serious failures in maternity and neonatal care and four high-level recommendations. These focused on leadership, organisational culture, governance, the use of data to identify risk, and how services listen and respond to families.

This approach reflected an explicit judgement by the investigation Chair that previous inquiries had not prevented similar failures being repeated.

> *"Firstly, lots and lots of detailed recommendations don't work. We know that. We've tried it so many times and we know it just doesn't work. But secondly, they also risk missing the point, which is that you've got some really difficult underlying issues here."* (Dr Bill Kirkup, Chair of the Morecambe Bay Investigation and Independent Investigation into East Kent)

The recommendations were therefore intended to address underlying system conditions rather than prescribe detailed local solutions.

> *"We were saying at every stage these are systemic problems, these are national problems. Where places like East Kent or Shrewsbury and Telford or Morecambe Bay or wherever pop up, they're the symptoms. They're not the underlying cause. They're just the ones where it's hit the surface. We have to stop looking at it as if they're a series of, you know, individual, local situations that you can correct locally."* (Dr Bill Kirkup, Chair of the Morecambe Bay Investigation and Independent Investigation into East Kent)

At a local level, the Trust accepted the findings in full and established a maternity and neonatal improvement programme, overseen by the Trust Board. Governance arrangements were strengthened, including dedicated oversight structures, and the Trust undertook extensive engagement with families as part of a restorative response. Subsequent CQC inspections in 2024 identified significant improvements in maternity services, and the Trust has since exited the Maternity Safety Support Programme. Similarly to Shrewsbury and

Telford this process took several years. However, safety remains rated as 'Requires improvement' and some structural challenges persist, indicating that, while progress has been substantial, continued focus is needed to achieve consistent standards across all areas.

Alongside local action, the recommendations prompted national activity. This included work to strengthen maternity safety surveillance through the development of MOSS[9], as well as national programmes focused on leadership, culture and compassionate care.

These actions reflect the system-level intent of the original recommendations, with multiple bodies involved in developing and implementing changes across the NHS.

Given the focus on systemic issues, these recommendations require sustained effort over time to translate into consistent practice, rather than representing discrete actions that can be fully completed, particularly in areas relating to culture, leadership and professional behaviours.

The principle-based approach adopted by the investigation may reduce the risk of superficial compliance, but places greater reliance on leadership and governance to ensure that changes are embedded in day-to-day practice.

Overall, the Independent Investigation into East Kent[145] shows how a smaller number of high-level recommendations can shape both local improvement activity and wider system responses. It also highlights the challenge of translating these into consistent practices over time, even where there is evidence of clear improvement.

Summary across the three investigations

Across all three investigations, a number of consistent patterns can be observed in how recommendations have been implemented in practice.

Implementation activity is most visible in the period immediately following investigations, particularly at trusts. This period is typically characterised by strong leadership focus, additional resource, and sustained external oversight, which together support rapid and visible action.

In each case, there is evidence of significant initial implementation activity. This includes changes to leadership and governance arrangements, the introduction of new processes and training, and increased focus on safety and oversight.

However, maintaining these improvements over time has proved more challenging. As external scrutiny reduces, sustaining momentum becomes more difficult, particularly where changes depend on workforce stability, leadership continuity or changes in organisational culture.

While recognising that these findings are drawn from three selected trusts and may not be fully representative of all services, recommendations relating to structural or procedural change—such as governance arrangements, reporting processes or mandated training—were more likely to be implemented quickly, although not always sustained. In contrast, recommendations relating to culture, behaviours, teamworking and engagement with families were more likely to remain ongoing.

There is also evidence that implementation is progressed through a combination of local action and national programmes. National initiatives have supported more consistent adoption of some changes, particularly where they are accompanied by clear expectations, monitoring or external oversight.

Overall, the evidence from these cases suggests that implementation is not a one-off activity, but an ongoing process requiring sustained focus over time. While investigations can prompt rapid and significant change—particularly under conditions of strong leadership, resource and oversight—ensuring that improvements are embedded and maintained in everyday practice remains a persistent challenge. This is particularly the case for changes relating to culture, leadership and behaviours, and for improvements that depend on continued national support alongside local action.

How implementation takes place over time – national responses

Across the examples reviewed, initial action often begins within the first year following a major investigation or recommendation. This typically includes the development of national policy responses, local action plans, and new guidance or programme activity. However, translating these early responses into changes in everyday practice takes longer. The development and rollout of tools, training programmes and data systems commonly takes between one and three years, with further time required for these to become embedded in routine care.

This pattern can be seen across multiple cases. The Independent Review of Shrewsbury and Telford[146] led to rapid national action, yet an updated version of the Saving Babies' Lives Care Bundle[147]—incorporating learning from the report—was only introduced in June 2023, around a year later. Similarly, recommendations from the Independent Investigation into East Kent[148] led to the development of MOSS,[149] which began national rollout from 2025 following a period of development and testing. Earlier recommendations show a comparable pattern: the Morecambe Bay Investigation[150] contributed to the Safer Maternity Care action plan,[151] published in 2016, and to the PMRT, introduced nationally in 2018.

These examples illustrate a consistent sequence from policy response, through development and rollout, to eventual embedding in practice. While initial responses can be mobilised relatively quickly, the supporting infrastructure required for implementation—such as tools, training, and data systems—extends the timeframe.

There are also consistent differences in how different types of change are implemented. Actions that introduce clear processes or systems—such as governance arrangements, reporting requirements or mandated training—tend to be implemented more quickly. By contrast, changes that depend on behaviour, culture or workforce stability are slower to deliver, more difficult to sustain, and more likely to remain ongoing.

Overall, implementation is best understood as a staged and variable process. It moves from initial response and programme development through to rollout and, over time, embedding in practice. These timescales require realistic expectations about the pace of change, alongside sustained focus and oversight. Variation between organisations further shapes how quickly change is realised in practice.

Table 4. Indicative time from recommendations to new policy initiatives or tools at the national level

Recommendations	Action (year)	Time from recommendation to initial trust level action (excluding the time from initial launch of action-to-action becoming business as usual)
The Morecambe Bay Investigation (March 2015)	Safer Maternity Care Action Plan (2016)	1 year
MBRRACE confidential enquiry finding regarding lack of reviews when a baby dies (2015)	PMRT (January 2018)	2-3 years
The Independent Review of Shrewsbury and Telford (March 2022)	Update to the Saving Babies' Lives Care Bundle version 3 (June 2023)	1 year
	Three-year delivery plan for maternity and neonatal services (March 2023)	1 year
The Independent Investigation into East Kent (October 2022)	Update to the Saving Babies' Lives Care Bundle, version 3 (June 2023)	Less than 1 year
	MOSS (December 2025)	3 years
	Three-year delivery plan for maternity and neonatal services (March 2023)	Less than 6 months

Barriers and enablers to making improvements and implementing recommendations

Evidence from previous investigations, trust responses, and national implementation analysis indicates that recommendations have often been implemented in form but not consistently embedded or sustained in practice. Across the system there has been a strong ability to initiate action following failure, but this has not reliably translated into lasting improvement in the everyday delivery of care.

Across the evidence reviewed, barriers and enablers to implementation can be grouped into five broad themes, reflecting factors at system, organisational and practice level. This approach draws on existing literature on implementation in healthcare,[152] including reviews of barriers and enablers to clinical guideline implementation, which identify common influences across healthcare systems, patient and population factors, guidelines and standards, organisational capacity, and health professional practice.

Table 5. Barriers and enablers to the implementation of recommendations

Theme	Barriers to implementation	Enablers of implementation	What this means in practice
Healthcare system and systemic factors	• Workforce shortages, turnover and limited capacity reduce the ability to deliver and sustain change. • A high volume of recommendations and overlapping requirements can create competing priorities. • Implementation is often fragmented, with limited coordination or sequencing across programmes.	• Nationally coordinated programmes, alignment between organisations, and structured implementation approaches support more consistent delivery. • Regulatory and financial mechanisms also support adoption.	• Implementation is more effective when it is organised as a coordinated, system-wide programme, rather than a set of separate or competing initiatives.

Theme	Barriers to implementation	Enablers of implementation	What this means in practice
Patient and population factors	• Family and service user perspectives are not always consistently incorporated into implementation. • Capacity to support meaningful engagement can be limited. Inequalities are not always addressed at the point of design.	• Engagement with families, co-production, and approaches that reflect the needs of different populations support more effective and inclusive implementation.	• Implementation is strengthened where care is designed with, and responsive to, the needs and experiences of women, birthing people and families.
Guidelines and standards	• Recommendations can be complex, overlapping or difficult to interpret. • Where recommendations lack clarity, ownership or measurable outputs, they are harder to implement and monitor.	• Clear, standardised guidance, with defined expectations, ownership and measurement, supports more consistent implementation.	• Recommendations are more likely to be implemented where they are clear, specific and actionable.
Organisational capacity	• Limitations in data quality, interoperability and infrastructure reduce the ability	• Data systems, surveillance tools, administrative support and digital infrastructure enable monitoring, learning and sustained improvement.	• Implementation is more sustainable where it is supported by functioning systems, reliable data and adequate resources.

Theme	Barriers to implementation	Enablers of implementation	What this means in practice
	to monitor progress and support learning. - Wider enabling conditions, such as estates and resourcing, are not always addressed.		
Health professional practice	- Cultural and behavioural factors, such as hierarchy, communication and leadership can limit implementation. - Changes that rely on behaviour or culture are more difficult to deliver and sustain.	- Training, education, leadership development and multidisciplinary working support changes in practice.	- Structural changes are implemented more quickly, while changes in culture and behaviour take longer and require sustained effort.

What we heard from women, birthing people and families and service user voice representatives

There was a perception that no clear system exists to track whether recommendations have been implemented, by whom, or with what effect, making it difficult for both families and the system to assess progress.

Participants also raised concerns about how recommendations are framed, noting a lack of clarity about who is responsible for delivery, with limited national ownership and unclear accountability for ensuring implementation.

They also described many recommendations as high-level, non-specific or advisory, meaning they are not consistently applied in practice.

> *"I could probably count on the fingers of one hand out of [the number of recommendations], how many of them were actually SMART objectives? So, what we've got is just, sort of, vague musings of people and reports that have chucked some stuff together and said, we should say this thing. And then we get into the challenge of, if you can't pin something down, and you can't assure against it in a way that is robust and meaningful, what you end up with is […] reports that just sit on the shelf gathering dust because people don't know how to do it, or they don't know exactly what's being asked of them, or how their compliance with that thing is going to be measured."* (Family member)

The repetition of recommendations over time was interpreted as indicating that earlier recommendations had not been fully implemented or embedded.

Families further highlighted that recommendations often generate initial activity but are not sustained over time.

What we heard from staff and system leaders

Staff and system leaders consistently highlighted the difficulty of implementing recommendations effectively and sustaining their impact over time.

> *"We have a very complex system that finds it difficult to implement safety recommendations effectively."* (Professor Ted Baker, Chair, Health Service Safety Investigations Body)

Staff described a gap between recommendations and meaningful change in practice. Recommendations were often experienced as only partially implemented, inconsistently applied, or focused on demonstrating compliance rather than delivering lasting improvement.

This was closely linked to resourcing. Staff and national leaders highlighted a mismatch between recommendations and the workforce, funding and infrastructure required to deliver them. In this context, implementation was often described as under-resourced or a *"tick-box"* exercise.

> *"For as long as we don't have staffing models correct, we're always […] firefighting […] we don't have that time […] to learn and improve the services."* (National body representative)

Staff consistently described uneven implementation across organisations, contributing to variation in care. While some trusts were seen to make progress, others struggled due to differences in capacity, leadership and system support. At a system level, respondents also highlighted fragmentation, with multiple organisations producing overlapping or uncoordinated recommendations. This made prioritisation difficult and diluted focus. Implementation was further hindered by unclear accountability and oversight, with multiple organisations and layers of responsibility making it difficult to establish ownership for delivery.

> *"And I think this is one of the problems with investigations, however good the investigation, the people receiving the learning have to be receptive to it and I think a lot of the investigation work going on locally has improved a lot, but I think the system hasn't necessarily matured enough to take on board the learning for these investigations. And so, I think there's a real issue there about governance, both within organisations, but also potentially nationally."* (Professor Ted Baker, Chair, Health Service Safety Investigations Body)

A sense of *"investigation fatigue"* was described, particularly where repeated inquiries had not led to sustained improvement. Many noted a recurring pattern in which successive national reviews identify similar issues—particularly staffing and resource constraints—without these translating into lasting change.

In addition to the impact on staff, workforce feedback highlighted wider consequences, including on public confidence. Some respondents expressed concern that repeated inquiries, without visible or sustained improvement, risk contributing to fear and mistrust among the public and service users.

> *"Stop repeated national enquiries that are creating fear and mistrust within the public and focus on achievable recommendations that are adequately resourced to support implementation."* (Staff member)

In terms of impact, most staff did not describe clear or consistent evidence of sustained system-wide improvement resulting from previous recommendations. Where positive changes were identified, these were often linked to specific interventions, targeted programmes or local leadership, rather than to the recommendation process itself.

Part 4: Actionable insights – what the evidence suggests is needed for implementation and sustained improvement

The review of previous maternity and neonatal recommendations shows that the core challenge facing the system is not a lack of guidance, but the ability to put that guidance into practice and sustain change over time.

Across the past decade, a consistent pattern can be seen. Periods of intense activity often follow investigations or reviews, supported by external scrutiny and increased focus. This can lead to visible progress in the short term. However, over time, this momentum can reduce, and some changes are not fully embedded in everyday practice.

This is particularly the case where recommendations depend on workforce stability, leadership continuity or changes in organisational culture, rather than on more clearly defined technical or procedural changes.

This evidence suggests that issuing further recommendations of a similar type is unlikely, on its own, to produce different outcomes. The challenge lies less in what is recommended, and more in how recommendations are put into practice.

While past recommendations have covered a wide range of areas, their impact has varied depending on how they have been implemented in practice.

Recommendations are more likely to be successfully embedded where they are supported by clear ownership, specific actions, measurement, and wider system support. Nationally standardised tools, assurance processes and programmes supported by regulatory or financial mechanisms have generally been implemented more consistently than recommendations that rely on local interpretation alone.

By contrast, recommendations framed at a high level, or those focused on culture, leadership or teamworking without sustained support, have been more difficult to implement and maintain over time.

The review also highlights the importance of sequencing and coordination. Recommendations have often been progressed as separate, time-limited actions, rather than as part of a coordinated, multi-year programme of improvement. Where implementation has been structured, phased, and supported by national systems, governance and feedback mechanisms, progress has been more consistent and more likely to be sustained.

This points to the need to focus not only on what should change, but on how change is delivered and sustained over time. This includes greater emphasis on coordination, clear ownership, and designing implementation in a way that can be maintained in everyday practice.

Building on this, the evidence points to the need for a more focused and structured approach. This includes consolidating and prioritising expectations, clarifying ownership and accountability across national, system and provider levels, and designing implementation as a coordinated, phased and adequately resourced programme rather than a series of standalone actions. Future improvement is more likely where emphasis shifts from generating additional recommendations to strengthening the systems, infrastructure and governance required to ensure that existing knowledge is delivered reliably and sustained in practice.

Annex 4: The Investigation's Chair and panel of Expert Advisors

The Right Honourable Baroness Valerie Amos LG CH PC

Baroness Valerie Amos was appointed as the Chair of the independent National Maternity and Neonatal Investigation in August 2025. Valerie Amos has been Master of University College, Oxford since 2020. Prior to this she was the Director of the School of Oriental and African Studies (SOAS), University of London. She was the United Nations (UN) Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator from 2010 to 2015. Before her appointment to the UN, she served as British High Commissioner to Australia.

Valerie Amos was an adviser to the Mandela Government on leadership and change management issues and was Chief Executive of the Equal Opportunities Commission between 1989 and 1994. She was Parliamentary Under-Secretary of State at the Foreign and Commonwealth Office 2001-2003, Secretary of State for International Development 2003 and Leader of the House of Lords and Lord President of the (Privy) Council 2003-2007.

She has served on the board of several Foundations including the UN and Mastercard Foundations and is co-founder and Patron of the Amos Bursary. She was also a non-executive Director at the University College London Hospital Trust and chair of the Board of Governors of the Royal College of Nursing Institute.

Dr Rachel Bartlett

Dr Rachel Bartlett FRCA MRCP is a Consultant Anaesthetist within Imperial College Healthcare NHS Trust. She has worked as a consultant anaesthetist since 2013, with extensive experience across emergency, trauma and obstetric anaesthesia. She worked and trained across many of London's obstetric units and spent the COVID-19 pandemic redeployed in intensive care. Her current clinical practice includes anaesthesia for obstetrics, high risk obstetric anaesthetic clinic, gynaecology, emergency surgery and major trauma, giving her a broad and varied portfolio of work. Rachel is also a partner in Lindo Anaesthesia, providing private obstetric anaesthesia care on the Lindo Wing.

Rachel has a longstanding commitment to medical education and professional development. She served as Director of Medical Education for over six years, supporting the training and wellbeing of resident doctors across multiple medical and surgical specialties and before that as Unit of Training Lead in Anaesthesia for five years. Alongside her educational leadership roles, she is a Leadership and Management Level 5 Coach.

A particular area of interest for Rachel is the 'second victim effect', supporting staff through incidents, complaints and investigations. She is passionate about fostering supportive learning environments and promoting the development, resilience and wellbeing of the medical workforce.

Dr Alison Bedford Russell

Dr Alison Bedford Russell is a neonatologist who held consultant posts at St George’s and Chelsea and Westminster Hospitals, London, and Heart of England NHS Trust (where she was Hon Associate Clinical Professor, Warwick Medical School). Additionally, she held clinical and leadership roles as Medical Director at Birmingham Women’s and as Deputy Chief Medical Officer at Birmingham Women’s and Children’s NHS Foundation Trust, and Deputy Division Chief of Neonatal Services (Sidra Medicine, Qatar).

Alison was clinical lead for the South West Midlands maternity and neonatal network and subsequently Clinical Director for the West Midlands Maternity and Newborn Strategic Clinical Network. Her research interests include neonatal infection, and she was a founder member of the Newborn Life Support course.

Until retirement in July 2025, she was Neonatal Clinical Co-Director for the Liverpool Neonatal Partnership, comprising Alder Hey Children’s Hospital and Liverpool Women’s.

Dr Christine Ekechi

Dr Christine Ekechi is a Consultant Obstetrician and Gynaecologist at Queen Charlotte’s & Chelsea Hospital, Imperial College Healthcare NHS Trust, with a specialist interest in early pregnancy and gynaecology.

Alongside her clinical work, Christine is a nationally influential voice on women’s health equity. She is the Founder and former Co- Chair of the RCOG Race Equality Taskforce—the first initiative of its kind in any medical Royal College worldwide—bringing together leaders across healthcare, academia, and government to reduce disparities in reproductive and maternity outcomes. As well as serving as an Expert Obstetric Advisor to the National Maternity and Neonatal Investigation, Christine provides strategic expertise to the NHS Race and Health Observatory, Baby Lifeline, and multiple university research, policy and parliamentary groups. She chaired the 2025 National Fibroid Treatment Pathways Roundtable at the RCOG, working to standardise care across England. She is also an invited speaker at national and international conferences, major corporations, and policy forums.

A published author in The Lancet, BMJ, Reproductive Health Matters and other peer-reviewed journals, Christine also contributes chapters to major Obstetrics & Gynaecological textbooks and supervises postgraduate research. Her academic interests span maternal and gynaecological health, reproductive justice, early pregnancy care and the intersection of race and health outcomes.

Professor Alexander Heazell

Professor Alexander Heazell is Professor of Obstetrics and Director of the Tommy's Stillbirth Research Centre, University of Manchester, the Regional Lead Obstetrician for the North-West of England and a Consultant Obstetrician at Saint Mary's Hospital.

His research portfolio includes basic science, clinical and qualitative research studies to gain better understanding of the causes and consequences of placental dysfunction, to prevent stillbirth and improve care for parents after stillbirth or perinatal death.

Professor Heazell has received over £7M of grant income and has published over 340 research papers and received national and international awards for his work on stillbirth and placental dysfunction, and for improving care. He led the recent Stillbirth Priority Setting Partnership and was one of the team for the 2016 Lancet Ending Preventable Stillbirth Series. He is a past chair of the International Stillbirth Alliance. He has led national studies to demonstrate the effectiveness of the Saving Babies Lives Care Bundle and an evaluation of PMRT reviews and MNSI.

Professor Heazell is the national lead for Rainbow Clinic, a specialist clinical service for parents in pregnancy after loss. He passionately believes that a better understanding of placental disease will improve outcomes for mothers and babies.

Dr Bill Kirkup CBE

Dr Bill Kirkup first worked in the NHS as a nurse in 1968. He qualified as a doctor in 1974, and trained in obstetrics and gynaecology, later gynaecological oncology. He switched to public health and medical management, becoming Regional Director of Public Health for Northern and Yorkshire Regional Health Authority in 1999. In 2005 he became Associate Chief Medical Officer for England.

Bill volunteered to work on public health and reconstruction in conflict zones, working alongside military operations in Kosovo (1999), Iraq (2003, 2005) and Afghanistan (2007/08). After attachment to a US Civil Affairs Battalion in Baghdad, he was asked to set up a programme in 2005 to bring 450 Iraqi clinicians to the UK in groups to update their clinical skills, which led to the implementation of demonstration sites in Iraq. He was asked by the Surgeon General to investigate replicating this for Afghan clinicians.

Since retiring, Bill has chaired independent investigations, including Oxford Children's Heart Surgery, Jimmy Savile at Broadmoor, Morecambe Bay Maternity and Liverpool Community. He was a member of the Hillsborough Independent Panel, where his review of the 1989 postmortem examinations led to the original inquest verdicts being quashed. He chaired the Independent Investigation into East Kent Maternity Services, which reported in 2022.

Dr Bill Kirkup decided to stand down from his role on 22 June 2026 as one of the Expert Advisors for the National Maternity and Neonatal Investigation as a result of not being able to *agree on the specific wording of the conclusions on normal birth ideology for inclusion in the final report*.

Dr Tom McEwan

Dr Tom McEwan has been a Nursing and Midwifery Council (NMC) registered midwife since 1999. He has practiced across maternity and neonatal care as a midwife and an advanced practitioner in neonatal nursing.

Tom is currently Principal Educator within the Women's, Children, Young People and Families team and the Professional Lead Midwife for Public Services Delivery Scotland. He is the strategic lead for the Scottish Multiprofessional Maternity Development Programme (SMMDP) and has additional responsibility for national midwifery, maternity and neonatal workforce and educational developments in Scotland. He is the Consultant Editor for the British Journal of Midwifery and has published numerous peer reviewed articles and book chapters.

Tom is a Fellow of the Royal College of Midwives, a Senior Fellow of the Higher Education Academy and holds a Doctorate in Professional Studies. His years of experience as a midwife, advanced clinical practitioner, academic, educator, researcher and professional leader have provided him with expert knowledge of the midwifery, maternity and neonatal care systems.

Huda Mohamed MBE

Huda Mohamed MBE is a specialist midwife at Whittington Health NHS Trust, recognised with an MBE for her outstanding contributions to midwifery and women's health. She is a nationally respected expert in FGM, leading efforts to improve care pathways, raise awareness and support affected women through culturally sensitive and trauma-informed approaches.

With a career rooted in clinical excellence and advocacy, Huda has played a pivotal role in shaping maternity services that are inclusive and responsive to diverse community needs. Her work bridges frontline care and strategic policy, and she is frequently called upon to advise on best practices in safeguarding, education and service development related to FGM and broader women's health issues.

Huda's leadership extends beyond her Trust, influencing national conversations around equity in maternity care and contributing to multidisciplinary collaborations aimed at improving outcomes for vulnerable populations. Her recognition with an MBE reflects her dedication to compassionate care, innovation and systemic change.

Dr Edile Murdoch

Dr Edile Murdoch is a consultant neonatologist at NHS Lothian, Edinburgh and previously Addenbrooke's hospital, Cambridge. She has held maternity and neonatal leadership roles across Scotland and England including clinical director posts and chair of the Scottish perinatal network adverse event review group.

She has co-written national reports: the Scottish maternity and neonatal (perinatal) adverse event review process guidance (2021); MBRRACE-UK perinatal confidential enquiries into the care of migrant women, and Asian, Black and White women; the Scottish National Bereavement Care Pathway; and co-chaired the British Association of Perinatal Medicine (BAPM) perinatal palliative care frameworks.

Edile has significant experience of national and board level investigations as member of the Scottish Best Start review and implementation groups (2017-2024) and member of the oversight panel for the all-Wales maternity and neonatal assessment, published in February 2026. Edile is a national specialty advisor and the clinical lead for the recently launched MOSS programme (NHSE).

Professor Julia Sanders

Professor Julia Sanders is a Nursing and Midwifery Council (NMC) registered nurse and midwife with her nursing experience being in adult intensive care. Julia has over 35 years' clinical midwifery experience within the NHS including as a Consultant Midwife at Cardiff and Vale University Health Board. Throughout her career Julia has worked closely with midwifery, obstetric, anaesthetic and neonatal colleagues to develop and provide safe, evidenced-based, compassionate care for women, babies and families. Julia has held the post of Professor of Clinical Midwifery at Cardiff University since 2017 with her research methodological expertise being in randomised controlled trials and the use of NHS and other routine data for research purposes.

Julia has wide research interests with studies including: exploring the effectiveness of the Family Nurse Partnership Programme in England and Scotland; the safety of waterbirth for mothers and their babies; improving care during postpartum haemorrhage; and the support of infant feeding.

Lesley Sharkey

Lesley Sharkey is Nurse Director for Acute Services at NHS Tayside. Since beginning her midwifery career in 1996, she has worked across a wide range of women's health and early years settings in both Scotland and England. Lesley has held clinical, managerial, leadership and strategic roles in nursing and midwifery, spanning inpatient and community services. She has a strong interest in governance, patient safety and continuous learning to improve care.

As a Scottish Quality and Safety Fellow, she gained experience in quality improvement and leadership, which she continues to embed in her work. She served on the expert review panel for the Northern Ireland RQIA review of maternity services governance and was also an external panel member for several Scottish Boards to support maternity service improvements.

Lesley has developed a passion for individualised, relational care, recognising its profound impact on people using services and the staff providing them. She chaired a national ministerial taskforce subgroup, working with the Scottish government to produce recommendations for nursing and midwifery, particularly around staff wellbeing. Lesley's core values centre on hearing and respecting those who use services, promoting shared decision-making, and ensuring safety above all.

Professor Joht Singh Chandan

Professor Joht Singh Chandan is a Clinical Professor of Public Health at the University of Oxford. His work focuses on improving population health, reducing inequalities and strengthening trauma-informed approaches across the NHS and wider health and care system. In 2024, he was appointed as the youngest Clinical Professor in the UK, reflecting his contributions to research, policy and public health practice. In 2025, he was appointed as a National Institute for Health and Care Research (NIHR) Research Professor.

His research focuses on identifying and addressing health inequalities, particularly among underserved and marginalised populations, including people affected by violence, abuse and other forms of adversity. He has published over 150 peer reviewed articles and manages more than £71 million in research funding.

Joht leads several national and international programmes relevant to maternity safety, inequalities and trauma-informed care. These include co-leading the NIHR Maternity Disparities Challenge and the NIHR Global Health Research Group on Violence Against Women and Children. He also advises national policy work including the UK government National Youth Strategy and contributes to The Lancet Commission on Violence Against Women and Children.

Derin Webb

Derin Webb is a midwife lead for cultural safety and ethnic minority engagement in Manchester and is also clinical lead for the Equity and Equality action plan for the Greater Manchester Local Maternity and Neonatal System (LMNS). She works at both strategic and system levels to address inequities in outcomes and experiences, ensuring services are inclusive, responsive, and shaped by the needs of diverse communities. Derin is also a Clinical Fellow to the Chief Midwifery Office Black and Minority Ethnic Strategic Advisory Group in the North West.

With a background in immigration and asylum law, alongside experience in policy, community engagement, international development and human rights, Derin brings a strong social justice lens to her work. She is committed to protecting birthing rights and advocating for informed choice, particularly for individuals from multi-ethnic and multicultural communities who may face barriers to equitable care.

Derin has nearly two decades of experience in the voluntary sector, leading community development, capacity-building and advocacy initiatives. She is co-founder of Midwives Against Racism, a platform supporting reflective practice and learning to address racism in pregnancy and birth.

Annex 5: Stakeholders who provided evidence to the Investigation

We would like to thank all the stakeholders who engaged with the Investigation and generously shared their evidence, expertise and lived experience.

We are especially grateful to those who organised and facilitated evidence sessions and family panels, creating opportunities for families and communities to share their experiences and helping to ensure that their voices were heard throughout this work.

Engagement with All-Party Parliamentary Groups (APPGs)

- Baby Loss APPG
- Birth Trauma APPG
- Black Maternal Health APPG
- Maternity APPG
- Patient Safety APPG.

Interviews with national leaders

The team completed interviews with the following national leaders:

Name	Role	Organisation
Marie Washbrook	Director	Birthrate Plus
Dr Stephen Wardle	President	British Association of Perinatal Medicine (BAPM)
Dr Emma Ferriman	President	British Maternal and Fetal Medicine Society (BMFMS)
Dr Arun Chopra	Interim Chief Executive	Care Quality Commission (CQC)

Name	Role	Organisation
Dr Toli Onon	Chief Inspector of Hospitals	Care Quality Commission (CQC)
Professor Sir Mike Richards	Former Chair	Care Quality Commission (CQC)
Sir Julian Hartley	Former Chief Executive	Care Quality Commission (CQC)
Donna Ockenden	Midwife with extensive experience in previous investigations	Chair of the Independent Reviews of Shrewsbury and Telford Hospital NHS Trust and Nottingham University Hospitals NHS Trust
Dr Bill Kirkup	Independent healthcare consultant with extensive experience in previous investigations	Chair of the Morecambe Bay Investigation and Independent Investigation into East Kent Maternity Services
Dr Aidan Fowler	Deputy Chief Medical Officer for England National Director of Patient Safety	Department of Health and Social Care (DHSC) NHS England (NHSE)
Elizabeth O'Mahony	Director General, Finance Chief Financial Officer	Department of Health and Social Care (DHSC) NHS England (NHSE)
Ollie Clarke	Director of Capital	Department of Health and Social Care (DHSC) and NHS England (NHSE)

Name	Role	Organisation
Professor Sir Chris Whitty	Chief Medical Officer for England	Department of Health and Social Care (DHSC)
The Rt Hon Jeremy Hunt MP	Former Secretary of State	Department of Health and Social Care (DHSC)
The Rt Hon Wes Streeting MP	Former Secretary of State	Department of Health and Social Care (DHSC)
Charlie Massey	Chief Executive	General Medical Council (GMC)
Professor Pushpinder Singh Mangat	Medical Director and Director of Education and Standards	General Medical Council (GMC)
Dr Eleri Adams	Neonatology Clinical Lead	Getting It Right First Time (GIRFT)
Professor Tim Briggs	Chair	Getting It Right First Time (GIRFT)
Dr Rosie Benneyworth	Interim Chief Executive Officer	Healthcare Services Safety Investigation Body (HSSIB)
Professor Ted Baker	Chair	Healthcare Services Safety Investigation Body (HSSIB)
Sandy Lewis	Director	Maternity and Newborn Safety Investigations Programme (MNSI)

Name	Role	Organisation
Dr Edile Murdoch	Clinical Lead	Maternity Outcomes Signal System (MOSS)
Professor Marian Knight	Director and Professor of Maternal and Child Population Health	National Perinatal Epidemiology Unit, University of Oxford
Dr Katie Gallagher	Chair	Neonatal Nurses Association (NNA)
Alex Mancini	National Lead Nurse for Neonatal Palliative Care	NHS England (NHSE)
David Robertson	Programme Manager, Maternity and Neonatal Programme	NHS England (NHSE)
Dr Penny Dash	Chair	NHS England (NHSE)
Duncan Burton	Chief Nursing Officer	NHS England (NHSE)
Kate Brintworth	Chief Midwifery Officer	NHS England (NHSE)
Professor Donald Peebles	National Clinical Director for Maternity	NHS England (NHSE)
Professor Ngozi Edi-Osagie	National Clinical Director for Neonatal Care	NHS England (NHSE)
Sir Jim Mackey	Chief Executive Officer	NHS England (NHSE)
Wendy Olayiwola	National Maternity Lead for Equality	NHS England (NHSE)

Name	Role	Organisation
Professor Habib Naqvi	Chief Executive	NHS Race and Health Observatory
Helen Vernon	Chief Executive	NHS Resolution
Paul Rees	Chief Executive	Nursing and Midwifery Council (NMC)
Dr Nuala Lucas	President	Obstetric Anaesthetists' Association (OAA)
Gill Walton	Chief Executive	Royal College of Midwives (RCM)
Fiona Gibb	Director of Midwifery	Royal College of Nursing (RCN)
Professor Nicola Ranger	Chief Executive	Royal College of Nursing (RCN)
Dr Alison Wright	President	Royal College of Obstetricians and Gynaecologists (RCOG)
Professor Steve Turner	President	Royal College of Paediatrics and Child Health (RCPCH)
Professor Jeremy Howick	Director	Stoneygate Centre for Empathic Healthcare
Professor Simon Brake	Chief Engagement and Innovation Officer	University of Warwick Medical School

We also requested an interview with the DHSC Interim Director General for Technology, Digital and Data. They declined, instead providing written evidence in collaboration with DHSC and NHSE technology, digital, and data representatives.

Panels with national bodies

The team completed panels with representatives from the following national bodies:

- ICB Chief Executive Officers (two panels specifically with those from the ICBs covering the 12 NHS trusts listed in the Investigation's Terms of Reference)
- Royal College of Midwives (RCM)
- Royal College of Midwives (RCM) Midwifery Educators
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Leaders from across the neonatal system.

Written evidence

We requested, and received, written evidence from:

- UK Health Security Agency (UKHSA)
- DHSC and NHSE technology, digital and data representatives
- Lead Midwife for Education, Birmingham University
- Lead Midwife for Education, Kingston University
- Lead Midwife for Education, Middlesex University
- Patient Safety Commissioner
- Faculty of Public Health
- Regional Chief Nurse, East of England
- Regional Chief Nurse, London
- Regional Chief Nurse, South East.

We requested, but did not receive, written evidence from:

- Director General for People, DHSC and NHSE
- National Clinical Director for Children and Young People, NHSE
- Neonatal Medicine College Specialty Advisory Committee
- NHS Kent and Medway Integrated Care Board (ICB)

- Other Lead Midwives for Education
- Other Regional Chief Nurses
- Royal College of General Practitioners (RCGP)
- The Association of Directors of Public Health.

Additional stakeholders who engaged with the Investigation

- Birth Companions
- Birth Trauma Association
- Bliss
- Friends, Families and Travellers
- Group B Strep Support
- HMP Peterborough
- Interlink Foundation
- LGBT Mummies
- MaternAble
- Maternal Mental Health Alliance
- Maternity and Neonatal Independent Senior Advocates
- Maternity and Neonatal Voices Partnership
- Neonatal Palliative Care Alliance
- National Childbirth Trust
- NeuroNatal
- Race Equality Engagement Group
- Roma Support Group
- Royal College of Obstetricians and Gynaecologists Women's Network
- Sands
- SignHealth
- The Dad Shift
- The Maternity Collective
- The Maternity Consortium

- Tommy's.

Family Campaigns

The Investigation team met with affected family groups in Banbury, Nottingham, Oxford and Sussex and with families campaigning to raise awareness of specific maternity health conditions, including perinatal mental health in East Kent, placenta accreta and vasa praevia.

Annex 6: Glossary of Terms

Term	Description
Accident & Emergency (A&E)	Accident & Emergency (A&E) is for serious injuries and life-threatening emergencies. It is also known as the emergency department or casualty.
Adverse outcomes	Adverse outcomes in maternity and neonatal care refers to unintended harm to mother or baby occurring during pregnancy, labour, birth or the immediate postnatal period. This includes pregnancy loss through miscarriage, stillbirth, or early neonatal death, and significant neonatal morbidity including hypoxic brain injury, seizures, or conditions requiring admission to neonatal intensive care. For women this includes maternal death or severe morbidity (such as severe haemorrhage, sepsis, or organ failure). The term encompasses both clinical events that were potentially avoidable and those that occur despite optimal care.
All-Party Parliamentary Groups (APPGs)	All-Party Parliamentary Groups (APPGs) are informal, cross-party groups formed by MPs and Members of the House of Lords who share a common interest in a particular policy area, region or country.
Anaesthetist	In maternity care anaesthetists provide women with epidural pain relief during labour, pain relief and care during caesarean or instrumental births, and provide specialist care to women with underlying medical conditions or pregnancy related complications.
Antenatal	The period between conception and birth.
Approved Educational Institutions (AEIs)	An Approved Education Institution (AEI) is the official status awarded by the Nursing and Midwifery Council (NMC) to an institution, or part of an institution, authorised to deliver NMC-approved nursing, midwifery, or nursing associate training programmes.

Term	Description
Artificial Intelligence (AI)	AI can be defined as the use of digital technology to create systems capable of performing tasks commonly thought to require intelligence.
Attrition	The natural decline in workforce size.
British Association of Perinatal Medicine (BAPM)	BAPM is a professional association and registered charity, dedicated to shaping the delivery and improving the standard of perinatal care in the UK.
Caesarean Birth	An operation in which a baby is born through a cut made in the wall of the abdomen and the uterus. It may be performed as a planned (elective) or an emergency procedure.
Care Quality Commission (CQC)	The Care Quality Commission is the independent regulator for health and adult social care in England.
Cerebral Palsy	Cerebral palsy is the name for a group of lifelong conditions that affect movement, co-ordination and other brain functions. It is caused by a problem with the brain that develops before, during or after birth.
Chief Executive/Chief Executive Officer (CEO)	The highest-ranking executive in an organisation.
Cisgender	Cisgender refers to individuals whose gender identity matches the sex assigned to them at birth.
Cisnormative	Cisnormative refers to the societal assumption that being cisgender is the norm or default.
Conditional Fee Agreement (CFA)	A Conditional Fee Agreement (CFA) is a contract where your lawyer’s legal fees are only payable if you win your case.

Term	Description
Consultant	A consultant is a senior doctor that has completed full medical training in a specialised area of medicine and is listed on the GMC's specialist register.
Continuum of Care	A patient-centred, integrated healthcare model that provides a seamless, coordinated system of care over time, matching services to a person's evolving needs.
Continuity of Care	Describes a situation where all the professionals involved in delivery of care share common ways of working and a common philosophy. The aim being to reduce conflicting advice experienced by women, and the same philosophy of care is experienced by the woman throughout the period of her care. Care may be provided by the same professionals or a small group of professionals.
Delivery suite	The delivery suite, or labour ward, specialises in high-risk maternity care, where women give birth and receive immediate postnatal care.
Department of Health and Social Care (DHSC)	DHSC is the UK government department responsible for health and adult social care policy.
Deprivation	Deprivation refers to a person's unmet needs, a lack of access to opportunities and the resources which we would expect to be available in our society.
Director of Midwifery (DoM)	A Director of Midwifery is a senior, highly experienced midwife manager and leader within the maternity service.
Doula	A non-medical professional, not employed by or affiliated with the NHS, who provides support to individuals and families before, during, and after childbirth.

Term	Description
Early Notification Scheme (ENS)	The Early Notification Scheme aims to investigate whether families are eligible for early compensation, reduce legal costs, make prompt payments to those eligible for support with care needs, and improve the experience of families who are making a clinical negligence claim and staff affected by the incident.
Electronic Patient Record (EPR)	An EPR is a secure digital version of a patient's hospital medical record.
Family Integrated Care (FICare)	Family Integrated Care is a model of neonatal care that promotes a culture of partnership between parents, carers and health care professionals working together to care for babies on the neonatal unit.
Female Genital Mutilation (FGM)	Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, but there is no medical reason for this to be done.
General Data Protection Regulation (GDPR)	Data protection legislation that controls how personal information is used by organisations, including businesses and government departments.
General Practitioner (GP)	General Practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment.
Gestation	The period of pregnancy counted in weeks.
General Medical Council (GMC)	GMC is the independent regulator of doctors, physician associates and anaesthesia associates in the UK.
Governance	The processes, structures, and accountabilities ensuring organisations deliver high-quality, safe, effective care, manage risks, and use resources efficiently.

Term	Description
Gynaecologist	A gynaecologist is a specialist doctor who focuses on the health of the female reproductive system and treats conditions ranging from routine menstrual and hormonal problems to complex surgical and fertility issues.
Health Building Note (HBN)	Health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.
Health Visitor	A qualified nurse or midwife with specialised training in community public health, focusing on the development and wellbeing of children aged 0–5.
Health Services Safety Investigation Body (HSSIB)	The Health Services Safety Investigation Body (HSSIB) investigate patient safety concerns across the NHS in England and in independent healthcare settings where safety learning could help to improve NHS care.
Heteronormative	Heteronormative refers to the assumption that all people are heterosexual and that heterosexuality is normal and natural.
Heterosexual	Heterosexual refers someone who has an emotional, romantic or sexual attraction towards someone of the opposite sex or gender.
Induction of labour	Starting labour artificially.
Information Technology (IT)	Information Technology (IT) refers to the digital infrastructure, software, and systems used to deliver, manage, and improve healthcare services.
Initial Assessment	The maternity pathway initial assessment, referred to as the booking appointment, is the first comprehensive, contact with a midwife to assess the health and social needs of a pregnant woman and their baby.

Term	Description
Integrated Care Boards (ICBs)	ICBs are NHS organisations responsible for planning health services for their local population.
Intensive Therapy Unit (ITU)	A hospital ward area that specialises in care of critically ill adults.
Intrapartum	The period between the onset of labour and immediately after birth.
In Vitro Fertilisation (IVF)	In vitro fertilisation (IVF) eggs are fertilised with sperm in a laboratory, and the embryo is placed in the woman's womb (uterus).
Kings Counsel (KC)	In the UK, King's Counsel (KC) refers to a set of barristers and solicitors who the monarch appoints to be a part of His Majesty's Counsel learned in the law.
Labour	The stages of childbirth. Labour is divided into three stages: first, second and third.
Labour ward	The delivery suite, or labour ward specialises in high-risk maternity care, where women give birth and receive immediate postnatal care.
Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO)	The Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) governs the provision of legal aid across England.
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning + (LGBTQ+)	LGBTQ+ is an umbrella term for individuals who are lesbian, gay, bisexual, transgender, and queer or questioning plus other sexual orientations and gender identities (including asexual, non-binary).
Local Maternity and Neonatal System (LMNS)	An LMNS is an NHS structure in England responsible for delivering safe, personalized, and equitable maternity and neonatal care. They bring together midwives,

Term	Description
	doctors, and user voices (via MNVPs) to improve services locally.
Maternity and Neonatal System	We define the maternity and neonatal system as all the care, support and services women, babies and families have lived experiences of, from the moment pregnancy begins, through labour and birth and for up to six weeks after birth. This includes pre-pregnancy advice and care, pregnancy care, labour, birth, neonatal care and postnatal care, including psychological support and bereavement care. We define neonatal care within this context specifically as care provided to a baby after birth. This is delivered within a maternity setting, either in inpatient wards or in the community, with the aim of avoiding unnecessary separation of mother or parent and baby. This includes immediate support at birth (such as resuscitation), neonatal transitional care delivered in partnership with neonatal clinicians, palliative care for babies with life-limiting conditions, and support from Neonatal Community Outreach Teams for babies with additional needs.
Maternity Assessment Unit (MAU)/Maternity Day Assessment Unit (MDAU)	A Maternity Assessment Unit or Maternity Day Assessment Unit is an outpatient service providing urgent, non-emergency, or planned monitoring during pregnancy and during the 6 weeks postnatal.
Maternal Mortality	Maternal mortality is the death of a woman during pregnancy, childbirth, or within a year of the pregnancy.
Maternity and Neonatal Voices Partnership (MNVP)	An MNVP is a local, independent organisation that listens to the experiences of women and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care.

Term	Description
Maternity and Newborn Safety Investigations (MNSI)	The Maternity and Newborn Safety Investigations programme is part of a national strategy to improve maternity safety across the NHS in England.
Maternity Outcomes Signal System (MOSS)	The Maternity Outcomes Signal System (MOSS) is a safety signal system designed to monitor near real-time routine data to alert maternity services of potential safety issues and enable prompt responses and escalation.
Midwife	Midwives are registered with the UK Nursing Midwifery Council and provide care and support to women, babies and their families while pregnant, throughout labour and during the period after a baby's birth.
Midwifery Led Care	Care for pregnant women where the midwife is the lead professional. Midwifery-led care is suitable for women who have a low risk, uncomplicated pregnancy.
Ministry of Justice (MoJ)	The Ministry of Justice is the government department at the heart of the justice system.
Miscarriage	Spontaneous loss of a pregnancy before 24 weeks' gestation.
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)	MBRRACE-UK is an organisation that conducts robust national surveillance and investigates the deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK.
Multidisciplinary team (MDT)	Health and care professionals from different disciplines working together as a team to support patients.

Term	Description
National Institute for Health and Care Excellence (NICE)	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.
National Institute for Health and Care Research (NIHR)	The National Institute for Health and Care Research (NIHR) is funded by DHSC to fund, enable and deliver health and social care research.
National Maternity and Neonatal Taskforce	The Taskforce will oversee improvements to NHS maternity and neonatal care in England, including addressing the recommendations of this Investigation.
Neonatal period	The neonatal period is the time from birth up to 28 days following birth. This includes babies born preterm and term.
Neonatal Death (MBRRACE UK definition)	A live born baby (born from 20 completed weeks gestation) who died before 28 days after birth.
Neonatal Unit	A hospital unit which provides specialist care to sick babies.
Neonatal Intensive Care Unit (NICU)	An area of a neonatal unit that cares for babies who require intensive care.
Neonate	A newborn infant.
Neonatologist	A neonatologist is a specialist doctor who cares for newborn babies, who are premature, seriously ill, or born with medical conditions requiring intensive or specialist support.
NHS	The National Health Service (NHS) was set up in 1948 to provide everyone in the UK with healthcare based on their needs, which is free to access.

Term	Description
NHS England (NHSE)	The executive non-departmental public body responsible for the overall management, planning, and delivery of healthcare services within the NHS in England.
NHS Race and Health Observatory	The NHS Race & Health Observatory work to identify and tackle inequalities experienced in health and healthcare by Black and minority ethnic patients, communities and the workforce in England.
NHS trust	A legal entity within the NHS in England responsible for providing healthcare services. There are several types of NHS trusts that provide specific services for example, acute, community, mental health, specialist and ambulance trusts.
Non-reciprocal IVF	A pregnancy supported by IVF where the same person provides the egg and becomes pregnant.
Nursing and Midwifery Council (NMC)	The NMC is the nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland.
Obstetrician	An obstetrician is a specialist doctor who cares for women during preconception, pregnancy, childbirth and postpartum.
Operational Delivery Networks (ODNs)	ODNs are focussed on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise.
Out of Guidance	Choosing maternity care that differs from that usually recommended.
Parity	The number of babies a woman has given birth to, including live births at any gestation and all births from 24 weeks or more.

Term	Description
Pathway	The structured, planned route a patient takes through the healthcare system.
Patient flow	The movement of patients through a healthcare system from initial contact, through to assessment, treatment, discharge and follow-up care.
Patient Reported Experience Measure (PREM)	Validated surveys that capture a patient's personal perspective on the care they received.
Patient Safety Integrated Response Framework (PSIRF)	The PSIRF sets out the NHS’s approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Perinatal period	The term perinatal period describes the time during pregnancy and the year following birth.
Perinatal Mortality Review Tool (PMRT)	A web-based, standardised tool for NHS maternity and neonatal units in the UK, which enables multidisciplinary reviews of care after a baby’s death (late miscarriage to 28 days post-birth).
Person-centred	Clinical decisions and care plans which are guided by an individual's specific needs, values and preferences.
Physiological birth	A spontaneous vaginal birth that occurs with minimal or no intervention.
Postnatal/postpartum	The period from birth until 6 weeks following birth.
Postnatal care	Care provided to women and babies, from birth for approx. 6 weeks.

Term	Description
Preterm Birth	A birth before 37 completed weeks of pregnancy.
Provider	An organisation that delivers healthcare services to patients as part of the NHS.
Psychological Safety	Psychological safety is the shared perception that an individual can express their opinions, raise questions, propose ideas, or admit mistakes without fear of being punished, rejected, or humiliated within their work environment.
Royal College of Midwives (RCM)	The RCM is the professional association and trade union for midwives and maternity support workers in the UK.
Royal College of Obstetricians and Gynaecologists (RCOG)	The RCOG is the professional association for obstetricians and gynaecologists in the UK and oversees the medical education, training and examination of obstetricians and gynaecologists.
Service model	How a particular service is organised and delivered in practice.
Society of Clinical Injury Lawyers (SCIL)	The Society of Clinical Injury Lawyers (SCIL) is a member organisation for specialist claimant solicitor firms dedicated to the field of clinical negligence.
Stillbirth (MBRRACE-UK definition)	A baby born from 24 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.
System	The organisations, processes and relationships involved in planning, delivering and overseeing care.
Term	Babies born at or after 37 weeks of pregnancy.

Term	Description
Third Sector	The Third Sector is comprised of non-governmental organisations that are value driven and which principally invest their surpluses to further social, environmental and cultural objectives.
Transitional care	An area of a postnatal ward for mothers and babies needing more than normal newborn care but not needing admission to the neonatal unit.
Trauma Informed Approach	Where a person, organisation, programme or system realises the impact of trauma and understands potential paths for healing and overcoming adversity and trauma.
Triage	A standardised system to determine clinical urgency and onward care pathways for women presenting for unscheduled pregnancy care. This is where women and birthing people are assessed, over the phone or in person, when they contact maternity services because they have a concern about their pregnancy. In this report, we describe triage as an A&E service for maternity, where the early warning signs of something going wrong can, and should, be spotted.
World Health Organization (WHO)	A specialist agency of the United Nations that acts as a coordinating authority on international public health.

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