

National review of maternity services in England 2022 to 2024

Our national review of maternity services in England, 2022 to 2024.

Download an easy read version of this report

What maternity services are like in England - September 2024 (Easy Read)
[20240919-NationalMaternityReport-EasyRead.pdf](#)

File title

What maternity services are like in England - September 2024 (Easy Read)

Keywords

[easy read](#)

Summary

The quality and safety of maternity services have remained under scrutiny in recent years. While a series of high-profile investigations identified key failings at specific NHS trusts, our National maternity inspection programme – an inspection of all hospital maternity locations that had not been inspected since before March 2021 – has shown many of the issues raised are widespread across England.

While we identified pockets of excellent practice, we are concerned that too many women and babies are not receiving the high-quality maternity care they deserve. Of the 131 locations we inspected between August 2022 and December 2023, almost half were rated as requires improvement (36%) or inadequate (12%). Only 4% of services were rated as outstanding and 48% were rated as good. At 12 locations, ratings for being well-led dropped by 2 ratings levels and at 11 locations, ratings for being safe dropped by 2 levels.

The safety of maternity services remains a key concern, with no services inspected as part of our inspection programme rated as outstanding for being safe. Almost half (47%) were rated as requires improvement for the safe key question, while 35% were rated as good and 18% were rated as inadequate. Where we had the most concerns, we used our enforcement powers to require trusts to make significant improvements to protect people from risk of harm.

While many of the issues we highlight in this report are systemic, with the right culture, services can improve and learn from one another. Alongside this report, we have worked with providers, maternity staff and stakeholder organisations to develop some additional resource materials which can be implemented at trust-level. These resources are available on our website and are aimed at maternity service staff at all levels to help support their efforts to deliver high-quality care and make improvements where needed.

In this report we refer to 'women', but we recognise that some transgender men, non-binary people and people with variations in sex characteristics or who are intersex may also use maternity services and experience some of the same issues.

Responding and learning from incidents

More work is needed to improve the way services report, learn and communicate with women following patient safety incidents. Although most services managed patient safety incidents well, we are concerned about the potential normalising of serious harm in maternity. For maternity staff, well recognised complications such as postpartum haemorrhages may be common and do not always constitute a patient safety event. However, the impact on women can be significant. We are concerned that women do not always receive the information they need to process what has happened to them and make informed decisions about future pregnancies.

Risk assessment and triage

We found significant variation for maternity triage as there are no national targets or standards for this area, and many of our inspections were carried out before the Royal College of Obstetricians and Gynaecologists (RCOG) released its [Good Practice Paper on Maternity Triage](#) in December 2023. Research by the Sands and Tommy's Joint Policy Unit supports this, showing that “guidance on how and when to contact triage is not clear and consistent between services”. While a ‘one size fits all approach’ may not be appropriate across all services, we are concerned that not everyone received a safe and timely assessment. We found instances where the triage phone went unanswered and when people arrived at hospital, issues with staffing and the triage environment meant some women were not assessed in a timely way. In some cases, delays in triage were so severe that women discharged themselves before being seen by a midwife or doctor

Recruitment and retention of staff

Our programme identified chronic issues around recruitment and retention of the maternity workforce as a key issue affecting the quality of care that women receive. It is vital that maternity services can recruit to maintain safe staffing levels in line with national standards. Staff should then be supported to carry out their roles with the appropriate levels of training. With high numbers of midwives being driven away from the profession by current pressures, leaders must prioritise the wellbeing of staff to foster an open and supportive culture. There is also work to be done to future-proof the workforce and attract students to a career in midwifery, as data from UCAS shows midwifery applications for June 2024 were at their lowest for more than 6 years.

Estates and environment

Unsuitable maternity estates emerged as another key barrier to high-quality care. We found some maternity units were not fit for purpose, as they lacked space and facilities and, in a small number of cases, appropriate levels of potentially life-saving equipment. Additional capital investment is needed to ensure women receive safe, timely care in an environment that meets their needs.

Inequalities and racism

We found significant differences in the way trusts collect and use demographic data to address health inequalities in their local populations. Reducing inequalities is imperative in saving lives and preventing harm to people with protected characteristics. Without national guidelines, we are concerned that trusts have no way of effectively evaluating whether initiatives to make maternity care more equitable are driving much-needed change. This is unacceptable given that, according to [MBRRACE-UK data](#) published in January 2024, Black women are still 2.8 times more likely to die during or up to 6 weeks after pregnancy compared with women in White ethnic groups. The data also showed that Asian women are 1.7 more times likely to die during the same period. Concerningly, we also found some trusts where both staff and people who were using the service experienced discrimination because of their ethnic background, or issues associated with having English as a second language or not their preferred language.

Communication with women and families

Communication with women and their families is not always good enough, particularly for those with protected equality characteristics. This affects their ability to consent to treatment and can perpetuate levels of fear and anxiety. Through our Give feedback on care service, many women told us that a lack of communication negatively affected their birth experiences. A cultural shift is needed so that all women are given the information they need, in a way they understand it, to make informed decisions and consent to treatment.

Foreword

Every pregnant woman wants a positive birth experience – and every member of staff working in a maternity service wants to provide safe, high-quality care. In most situations that's what happens, but sadly, it's not always the case. For some families who are impacted by poor maternity care, the damage is irrevocable. No family should ever have to suffer in this way and everyone working in the health and care system has a responsibility to do all they can to prevent it happening.

Maternity services have been and continue to be under significant scrutiny. In recent years, several high-profile investigations have highlighted worryingly similar failings - a sobering reminder that efforts to improve have not yet done enough to address the underlying issues preventing safe, high-quality care being delivered every time.

In 2020 we shared our concerns about the variation in quality and safety of maternity services across the country in a briefing paper [Getting safer faster: key areas for improvement in maternity services](#). Those concerns were further evidenced a year later in our thematic report on '[Safety, equity and engagement in maternity services](#)', and more recently CQC State of Care reports have singled out maternity as a service that has seen a marked deterioration in ratings over time.

It was within this context that we introduced a targeted national maternity inspection programme. The programme aimed to provide an up-to-date assessment of maternity care across England – and to explore what lies behind the lack of progress in some services. It began in August 2022 and involved on-site assessments of all hospital maternity locations that had not been inspected and rated since before March 2021.

This report brings together the findings from inspections of 131 hospital maternity units carried out as part of that programme, setting out the key themes, evidence of good practice and the common areas of concern. It makes recommendations for NHS trusts, the wider system and national bodies.

Our programme of inspections has shown that there are hospitals providing good maternity care and we found some excellent practice. However, we also identified some common issues and concerns that too many women and babies are not always receiving the high-quality service they should expect.

Sadly, we found that the failings uncovered by Donna Ockenden and Dr Bill Kirkup following their reviews of maternity in individual trusts are not isolated. Many of the factors apparent at East Kent and Shrewsbury and Telford are more widespread. Key issues continue to impact quality and safety – and disappointingly, none of them are new. Poor management of incidents with limited learning when things go wrong, failure to ensure safe and timely assessment at triage, unsuitable estates and access to essential equipment, a lack of oversight from trust Boards and significant challenges in recruiting and retaining staff.

We know the inequalities in outcome and additional risks experienced by women from Black and ethnic groups are well documented, yet we found huge differences in the way trusts collect and use demographic data to try to address those disparities. Significant concerns also remain regarding the quality of communication with women and their families, and a failure to engage with and listen to their needs.

These findings are all too familiar - so why do they persist and what is stopping us from moving forward? We need to be more honest about the reality of the problem and recognise that we all have a role to play to ensure sustainable improvement. This starts with a robust focus on safety where the culture that prevails does not accept risks as the norm and where staff are supported to deliver the high-quality care they want to provide. The recommendations made in this report aim to help us achieve that goal and to ensure good safe care for mothers and babies of today and in the future.

This report sets out some hard-hitting findings. However, this should not detract either from the positive steps that have already been taken to support change or from recognition of the dedication and commitment of the maternity workforce. Our findings show that the work to help improve safety already underway needs to continue and that there are specific issues that must be tackled as part of NHS England's three-year delivery plan for maternity. The findings also underline why it's so important that we encourage staff and services to take learning from CQC inspections that identify good care. Alongside this report we have published a number of new online resources intended to do just that by sharing what is working well as a source of practical guidance and support.

Without action, the danger is that poor care and preventable harm will become normalised. We cannot and must not let that happen.

We would like to express our sincere thanks to all those who have contributed to this report, In particular, our thanks go to all the families who shared their experiences with us to help ensure safer, better care in the future.

Recommendations

For NHS trusts

We recommend NHS trusts ensure all women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline. Women whose cases are referred to a review panel should have the right to attend the panel and the opportunity to co-produce improvements for future reviews.

For NHS trusts and integrated care boards (ICBs)

We recommend NHS trusts and integrated care boards:

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.
- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.

For NHS England

We recommend NHS England:

- Develops guidance and definitions of a patient safety event, where something unexpected or unintended happens in maternity services, ensuring reporting in line with Learn from Patient Safety Events (LFPSE), to tackle the issue of inconsistency in interpretation.
- Oversees the performance of maternity triage services to enable trusts to benchmark and improve. This is in line with the [Royal College of Obstetricians and Gynaecologists \(RCOG\) recommendation](#) to introduce “an agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine.” As outlined by RCOG, metrics should include “staffing requirements, agreed audit standards reported nationally, and frameworks for improvement.”
- Has oversight of gaps in middle-grade rotas and the proportion of time spent by consultants covering them. This supports recommendations in the Ockenden Review to introduce nationally agreed minimum levels of medical staff to cover the full range of maternity services at all times.
- Works with the Nursing and Midwifery Council and Royal College of Obstetricians and Gynaecologists to establish a minimum national standard for midwives delivering high dependency maternity care.
- Ensures trusts are proactively managing succession planning in midwifery services and, In line with recommendations from [Leadership for a collaborative and inclusive future](#) review, supports midwifery and obstetric staff to become effective future leaders.

For the Department of Health and Social Care (DHSC)

We recommend DHSC:

- Provides additional capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.
- Works with NHS England to ensure that this additional investment is ring-fenced and maternity services receive the investment they need.

For the Royal College of Obstetricians and Gynaecologists

We recommend the Royal College of Obstetricians and Gynaecologists takes our findings in relation to the surgical first assistant role in maternity services so that it is in line with the requirements set out by the Royal College of Surgeons.

For the Nursing and Midwifery Council

We recommend that the Nursing and Midwifery Council uses findings from our report to review their proficiency standards for midwives.

Methodology and evidence used

We inspected hospital maternity units that had not been inspected since before 2021, focusing on the safe and well-led key questions. The findings in this report are based on inspections of 92 NHS trusts across 131 locations. Overall ratings were determined using our [ratings principles](#).

Inspectors working on the programme received additional training and structured support to prepare for the role. This included briefings on the maternity pathway from midwives and senior specialists in our secondary care team. This covered what to expect when on site and the terminology used, as well as opportunities to shadow other inspectors and work with specialist advisors on site. Inspectors received specific guidance and used standardised templates to promote consistency, and could access additional support from a remote senior specialist at all times.

In 2019/20, we carried out 9 pilot inspections to develop a focused approach to inspecting maternity services. Learning from the pilots informed the National maternity inspection programme.

The aims of the National maternity inspection programme were to:

- show how services are responding to current challenges and what extra help they may need
- give women and their families an up-to-date view of the quality of maternity care at their local hospital trust
- show hospitals an objective assessment of what they are doing well and how they can improve
- help CQC understand what is working well so we can share good practice to help services learn and improve
- show where national action is needed to combat the challenges facing services.

This report explores the findings from our inspection programme to give a national view of the current state of maternity services in England. Evidence used in this report includes:

- inspection reports (thematic analysis of the first 85 published inspection reports alongside engagement with the inspection teams involved in all 131 inspections)

- responses received through our Give feedback on care service (around 10,000 maternity responses analysed for the report)
- open responses to the 2023 Maternity survey (around 1,250 responses)
- interviews with 10 midwives and 10 obstetricians from ethnic minority backgrounds
- focus groups with maternity leaders and frontline staff across 16 trusts to help us understand how trusts were ensuring that women from ethnic minority backgrounds had equitable access to pain relief.

As part of the programme, we commissioned THIS Institute to evaluate how we carried out the inspection programme and identify where we can improve. The final section of this report summarises this evaluation.

Safety

The National maternity inspection programme has identified widespread issues affecting the quality and safety of maternity services in England.

In the programme, we rated 47% of services as requires improvement or inadequate. Many of our concerns are not new – in our [Getting safer faster: key areas for improvement in maternity services](#) report, we highlighted that maternity services stood out from other services as not making safety improvements fast enough. Similarly, our [Safety, equity and engagement in maternity services](#) report identified that issues such as poor relationships between obstetric and midwifery teams, and failure to engage with and listen to local women, continue to affect the safety of some hospital maternity services.

Throughout the programme, the safety of women using maternity services has remained a key concern. This is reflected in our ratings, as no service was rated outstanding for being safe. In fact, for the safe key question, the majority of services were rated as requires improvement (47%), while 35% were rated as good and 18% were rated as inadequate. Where we had the most concerns, we used our enforcement powers to require trusts to make significant improvements to protect people from risk of harm.

We found a range of issues affected how safe services were. These ranged from compliance with training requirements, particularly in key areas such as measuring babies' heart rates and safeguarding, to how well services identified and managed the risk of deterioration in both women and babies. We also found concerns in relation to infection prevention and control in some services, with poorly maintained estates adding to their inability to provide safe care to women (see [the Estates section of this report](#)).

Throughout the programme, our inspection teams received high levels of challenge from some leaders working across the sector, which led to concern that poor care within maternity is being normalised. But all services must recognise the long-term, significant impact that pregnancy and birth can have on women. Many women told us about how their mental health had suffered before, during and after birth. In the UK, 4% to 5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth and data from MBRRACE-UK shows that although extended perinatal mortality rates decreased across the UK in 2022, they remain higher than in both 2019 and 2020.

Many of the issues we highlight in this report present serious risks to safety, such as unacceptable levels of variation in key areas such as [triage](#). However, in this section we look specifically at the way services reported, learned from and communicated with women following incidents.

Incident reporting

Although most services managed patient safety incidents well, more work is needed in this area to ensure that where women suffer serious harm in maternity services do not go unreported and are graded correctly. Issues and inconsistencies around incident reporting were identified as concerns in Dr Bill Kirkup's [report on maternity services in East Kent](#).

We are concerned that a lack of reporting – either because of a recognised complication that the trust does not believe meets the definition of a patient safety incident or that staff are overstretched – is leading to harm becoming normalised and opportunities for learning being missed.

For most of the inspection programme, services were reporting incidents to the National Reporting and Learning System (NRLS) – a central database for all patient safety incident reports. NRLS defines a patient safety incident as “any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare.” Towards the end of the programme, NHS England introduced the new [Learn from Patient Safety Events \(LFPSE\)](#) service and guidance, which has replaced the NRLS. This provides clearer definitions and distinguishes between physical and psychological harm.

Recognised complications may be common for staff and may not always meet NHS England's definition of a patient safety incident, which means they do not always need to be reported to NRLS or LFPSE. However, these complications can have a significant and long-lasting impact on women, and trusts have a statutory duty to notify CQC of such events. Trusts can do this through LFPSE and should monitor and respond to trends in these commonly occurring obstetric complications at a local level.

Many services did not have this oversight of commonly occurring obstetric complications. We found that services often had to access several different dashboards to get an overall picture of patient-related outcomes, which could at times be contradictory and unclear. In addition, we found inconsistencies in how trusts managed key metrics such as blood loss. Despite available guidance, not all services were measuring blood loss in all deliveries. This risks potential under-reporting and could mean national dashboard comparisons are less meaningful for oversight and improvement. We also found some services did not report all incidents of delays in care and controls of postpartum haemorrhage.

Not reporting incidents at a local level suggests a tendency for services to accept that maternity incidents are inevitable and that nothing in a woman's care or treatment may have contributed to them. But this is not always the case. Previous successful initiatives have shown that incidents such as [shoulder dystocia](#), where a baby's shoulder becomes stuck, can be preventable. For example, in 2000, North Bristol NHS Trust introduced simulation training to reduce shoulder dystocia. Since training was introduced, the trust believes that no babies have suffered permanent injuries. We also know that the likelihood and impact of postpartum haemorrhages can be effectively reduced with good antenatal monitoring of haemoglobin levels. Our concerns are reinforced by the recent Birth Trauma Inquiry, [Ending the Postcode Lottery for Perinatal Care](#), which described a "maternity system where poor care is all-too-frequently tolerated as normal".

While we recognise that postpartum haemorrhages (PPH) are not entirely preventable, services need to use evidence-based practice and guidance to optimise outcomes for women and acknowledge the impact that it can have on them. In addition, we know that women from Black and Asian backgrounds have an increased risk of PPH. Perinatal care for women from ethnic minority backgrounds should focus on preventative measures to optimise outcomes. However, as highlighted in our section on inequalities, not all services we inspected were monitoring outcomes by ethnicity.

Pressures on staff

When a patient safety incident occurred, most services managed this well in line with national guidance. However, we were concerned to find instances of patient safety incidents going unreported to NRLS because of time constraints. We found a significant number of incidents were not reported as staff were overstretched. Until more action is taken to ensure that incidents are recorded properly, and in a timely way, opportunities for improvement can be missed. Services rated as good and outstanding have a culture where incident reporting is encouraged, and feedback loops and improvement actions are normalised.

Maternity services tend to generate a significant number of incidents compared with other areas within a trust, and our inspection programme found that the size and make-up of governance teams were not always sufficient. Services often did not involve risk and governance managers, meaning midwifery staff were required to review incidents themselves. We were concerned about the impact of this on the quality and speed of reviews and the knock-on effect on staffing levels if midwives do not have protected time to review incidents. We consider this in more detail in the section on staffing.

Grading of incidents

As well as problems with reporting incidents, we are also concerned about variation in the way incidents were graded. The final report of the Ockenden review highlighted the importance of correctly grading patient safety incidents, ensuring the level of harm recorded reflects the actual harm the patient suffered.

NRLS states :

“Maternity, fetal and neonatal incidents such as intrauterine deaths should be reported to the NRLS, however a degree of harm of death should only be chosen if it is considered that a patient safety incident, such as an omission in care during the antenatal period, has led to or contributed to the death. The degree of harm can be amended and re-uploaded to the NRLS after further investigation.”

The way trusts and clinicians interpreted NRLS guidance on reporting incidents varied. While this variation exists, there is room for confusion, loss of learning and potential harm. Grading incidents based on whether omissions in care contributed to them, as outlined by the NRLS, does not take into consideration the actual physical and psychological harms that women experienced.

We saw evidence of this from incidents that are defined as ‘major obstetric emergencies’ (including [uterine inversion](#) and major haemorrhages over 2 litres) regularly being graded as no harm or low harm. Incidents graded as lower harm might mean opportunities to investigate and learn are missed. It could also result in no follow-up care or monitoring being organised, which may harm mothers and their babies. For example, one service used the perinatal mortality review tool, which showed an incident was graded less severely than it should have been. The trust originally highlighted that care issues ‘may’ have made a difference to the outcome for the baby, but a further review showed these issues were ‘likely’ to have made a difference.

We know that traumatic birth experiences can have a significant lasting impact on women and their families. Through our review, people told us about their experiences and the impact on them:

“This experience [was] not one I wish to ever have to go through again, this will be my first and LAST baby. When I think of my birth experience and the aftercare, I cry every time, it was purely awful.”

“I am now undergoing therapy for PTSD... I find it incredibly traumatic to explain what happened in detail.”

“I would love another baby at some point but am emotionally scarred and find the whole ordeal difficult to talk about so this is something I am very concerned about.”

LFPSE defines a patient safety incident as “something unexpected or unintended that could have or did lead to harm for one or more patients”. Recording guidance states, “if in doubt, it is always better to record a patient safety incident using the available information and best judgement”.

The guidance advises that where an unintended or unexpected outcome has been observed, but there is any uncertainty about whether an unintended or unexpected incident has occurred, the event should always be recorded to LFPSE to support national learning.

The new [Patient Safety Incident Response Framework](#) (PSIRF), introduced during the programme, moves away from the grading of incidents and prioritises compassion and engagement with the people involved in patient safety incidents. It also has a focus on improvement. We will monitor how trusts implement and use PSIRF in future inspections and ensure that harm and trauma are still given the appropriate consideration.

Our inspections found that even in a very defined system such as the previous serious incident framework, there was variation and under-reporting. Under PSIRF, providers should agree their incident response plan with their integrated care board (ICB). We will assess how trusts have done this, looking specifically at plans for maternity and neonatal services.

Investigating and learning from incidents

We expect leaders and staff to have a good understanding of service improvement, using processes to ensure that incidents are learned from. Leaders should encourage reflection and collective problem-solving.

While we found some pockets of good practice, the overall picture of how services investigated incidents was mixed. We were encouraged to find some services with midwives who specialised in learning from incidents and action plans being developed as areas were identified for improvement.

At some services, managers reviewed incidents potentially related to inequalities (see [the inequalities section](#) for more information). For example, one trust interrogated data to identify the impact of ethnicity on outcomes. Following this, the service recommended increased scanning for Pakistani women after data revealed they have a higher risk of having babies that are Small for Gestational Age (SGA). At another service, following a baby abduction incident, an abduction policy was implemented and security staff were employed. The service also introduced 2-hourly security rounds and a sign in register.

[Our improvement resource](#) provides more information on how services learned from incidents well. However, this good practice was not consistent across services. An investigation by MSNI into one service noted that staff did not acknowledge the needs of people with a learning disability using the maternity service.

We also found that delays in the reviewing process meant learning from incidents was slow-paced and learning was not always shared effectively with staff. Concerningly, in a small number of cases, it was not clear whether the service had produced any ongoing action plans or monitoring. In other instances, action plans were not up to date, or did not fully reflect the findings of the reported incident.

These issues expand beyond maternity services. A study published in the Journal of Patient Safety found that too often hospitals develop action plans with weak or ineffective interventions, which can fail to address key issues and result in significant gaps in translating investigations into meaningful improvement. It found plans typically included individual-focused interventions, even when problems were systemic.

Although we saw pockets of outstanding practice in many areas, there is a need to support trusts to adopt solutions that are working well in other maternity services. The lack of a system-wide approach to sharing learning is preventing maternity services from driving improvement by implementing strategies and interventions that work well elsewhere.

There are opportunities in the [Patient Safety Incident Response Framework](#) (PSIRF) to improve the way maternity services identify and embed learning from incidents through directing investigation resources towards incidents that they can learn most from. At one PSIRF early adopter site, we found the trust had created a continuous improvement and learning team that comprised midwives, patient safety and quality improvement practitioners. This team reviewed all incidents reported as moderate or above in the previous serious incident framework and identified learning opportunities. We welcome the increased focus on quality improvement and compassionate involvement of those affected by patient safety incidents.

Some serious events in maternity services have national requirements for reporting, such as intrapartum stillbirths and maternal deaths, which are reportable to the Maternity and Newborn Safety Investigations programme (MNSI). However, additional metrics for serious maternal morbidity outcome would improve oversight. These could include maternal admissions to the intensive therapy unit, returns to theatre, and maternal collapse.

Transparency and accountability

While recognised complications such as postpartum haemorrhages, obstetric anal sphincter injury (OASI), or shoulder dystocia do not always constitute a [patient safety incident](#) and may be recognised by staff as complications, it is vitally important to acknowledge the trauma experienced by the woman at the centre of each incident. Women need to understand what has happened to them, their recovery, and any potential impact on future pregnancies, but we are concerned that this does not always happen. Although research has identified improvement in this area, it shows there is still work to be done to make sure families are involved in investigations. Like other national reports, we heard through our Give feedback on care service that women did not always get a timely debrief or explanations of events, and this had had a negative impact on them.

Under the Health and Social Care Act 2008 [Regulation 20: duty of candour](#) requires providers to act in an open and transparent way. It aims to protect people's right to openness and transparency from their health or care provider and encourages families to talk about their experiences openly and without fear as they begin healing. This can also help build people's understanding of risk in future pregnancies. But the duty of candour only applies in certain situations, and we are concerned that when incidents are out of scope of the duty of candour, women do not always receive the debrief they need to process what has happened to them.

As well as the statutory duty of candour for all health and care providers, there is also a wider professional duty to be open and honest following incidents where the statutory duty of candour does not apply. The Nursing and Midwifery Council and the General Medical Council issued joint guidance on the professional duty of candour. The guidance is not intended for circumstances where a patient's condition gets worse due to the natural progression of their illness. It applies when something happens with a patient's care, and they suffer harm or distress as a result. There are opportunities to develop the principles of being open and honest with women in all scenarios, including after recognised complications of pregnancy.

We noted that in some trusts, staff can view potential complications as being normal – particularly during the intrapartum phase (during labour). However, we know from speaking to women who have experienced trauma that some of these 'normal' complications can have a significant impact. For example, although a grade 3 perineal tear may not warrant a patient safety incident, nor would it necessarily require the duty of candour to be instigated, it is vital that women still have the opportunity to discuss what happened, why it happened, and what it means for their future.

Through our Give feedback on care service, women told us about the impact of their traumatic birth experiences:

“I'm still traumatised, developed high level of anxiety and obsessive thoughts...”

“However after the traumatic time... even now 3 months on I am very upset about this... the first few weeks of my baby’s life were marred by flashback.”

“I have been left with trauma. Worst experience of my life.”

We also found that potentially serious incidents such as massive obstetric haemorrhage were normalised by many services if they perceived that they had ‘managed’ everything in line with guidance (generally either the Royal College of Obstetricians and Gynaecologists’ [Prevention and Management of Postpartum Haemorrhage guidelines](#) or the All Wales Maternity & Neonatal Network Guidelines on [Prevention and Management of Postpartum Haemorrhage](#)). Despite a number of services thematically reviewing incidents, we found this did not always translate into learning and improvement, such as a reduction in rates of PPH. In addition, even though services may have ‘managed’ an episode of haemorrhage well, a review and explanation of events would still be vital to help women to process their experience.

In many cases, managers involved women and their families in the investigation of incidents, which is a key part of incident response under PSIRF. We also heard about the importance of compassionate staff who provide people with clear information in a supportive setting:

“The team have been incredibly kind with our questions and making the next steps very clear, which makes them less daunting... They've really validated our experience and helped us to feel like what we are going through matters.”

We found examples of good practice where services applied duty of candour and issued letters in the first language of the family affected by the incident , but this was not always the case. We found evidence of inequality in how some services reviewed incidents. For example, in one service there were potential delays to the duty of candour process because the women involved did not speak English. It is vital that women are given the opportunity to be involved in investigations concerning their care. Not having English as a first language should not exclude people from being part of this important process.

At another service, we found good practice such as appointing a family liaison midwife to provide continuity of support throughout the process and auditing compliance with the duty of candour. But we also saw in a significant number of services that, although staff apologised following incidents, they were not always open and transparent with women and their families. Moreover, staff did not always provide clear information on the reason why things happened. Similarly, we identified occasions where women and families who were affected by serious incidents had not been involved in the investigation process, or their involvement was delayed. Through our Give feedback on care service, we have heard from women who are still waiting for answers and want to ensure mistakes are not repeated:

“I had a traumatic labour which resulted in a uterine inversion. I was rushed to theatre to be operated on, could not bond with my new baby and had to have a blood transfusion... We have since been into hospital for a meeting to discuss what happened but I still have no answers and I was meant to be contacted to have another meeting with a midwife and all these months later I am still waiting. I think the service I received was absolutely atrocious in what should have been a wonderful experience. The surgeon was amazing and so were some of the nurses on the ward. I hope something will be done about the care I received as I know I am not the only one and I wouldn't recommend to anyone.”

Through our engagement with families who have suffered a bereavement, we heard concerns about the lack of a complaint route, as services like PALS do not look into complaints where a patient has died. Family members also explained that policies and procedures following a loss can be left to staff to interpret, echoing our concerns around variation in the quality of follow up and communication. The families suggested that people affected by maternity failings should be involved in delivering training to midwives to ensure all families receive clear information and appropriate care in the future.

A pilot of Maternity and Neonatal Independent Senior Advocates started recently in England. The role has been introduced to support women and families affected by problems in maternity care. Maternity and Neonatal Independent Senior Advocates will help ensure that the voices of women and families are listened to and acted on. They will play an important part in ensuring women understand what has happened to them.

We recommend NHS trusts ensure all women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline. Women whose cases are referred to a review panel should have the right to attend the panel and the opportunity to co-produce improvements for future reviews.

We recommend NHS England develops guidance and definitions of a patient safety incident, where something unexpected or unintended happens in maternity services, in line with the Patient Safety Incident Response Framework (PSRIF), to tackle the issue of inconsistency in interpretation.

Triage

Maternity triage is an important first step for women who have an emergency or concern during their pregnancy (including early labour) or post-birth, offering advice, assessment and prioritisation.

On contacting the service, midwifery staff will carry out a preliminary assessment of their condition to determine the urgency of the situation and decide what further action is needed. In maternity services, the first assessment is often carried out over the telephone and includes:

- advising when women should make their way to their chosen birthing unit because they are in labour
- suggesting they should call back for further review
- making sure women are seen urgently if they have an obstetric issue that needs assessment, such as bleeding or if they have reduced fetal movements.

Despite being the first point of call when women have concerns, research by the Sands and Tommy's Joint Policy Unit found that guidance about how and when to contact triage is not consistent between services. It found “concerning levels of variation” about key topics including bleeding, waters breaking and reduced fetal movements.

Issues around assessments and the prioritisation of clinical risk have been highlighted in previous national reports, dating back several years. With no national targets or standards for operating maternity triage services, our inspection programme found significant variation. While a ‘one size fits all’ approach may not be appropriate across all services, we are concerned that not everyone received a safe and timely assessment, as many services developed their own tools, processes, and standard operating procedures. We found a lack of consistency across services and many were not able to audit the effectiveness of their triage system.

Consistency in this area would provide frontline staff with clarity when caring for women and babies.

Issues with triage emerged as an early finding from the programme. Following the first 20 inspections, we highlighted concerns around:

- patient prioritisation
- timeliness for initial assessment
- oversight of those waiting
- staff training and competence.

Unsafe practice in maternity triage went on to form the basis of 81% of enforcement actions issued to providers and was recognised as a safety concern in around a third of our inspections overall. Through our Give feedback on care service, we heard that women and babies were exposed to potential harm by delays in triage. Many women told us they had experienced significant delays in triage, even when they had been told they would need an urgent medical review because they had presented with high-risk scenarios.

All the obstetric services we inspected offered a form of triage service. Standalone midwifery-led units offer a limited dedicated triage service, with phone numbers to the main units. One service that did not offer a triage service provided a maternity helpline for women who needed advice.

Triage services also varied in terms of opening hours, with some services open 24 hours a day, 7 days a week, and others operating between a given time, often during daytime hours. Where the dedicated triage service was closed through the night, most services offered telephone triage and/or a triage system operated by a different department within the maternity service, such as the delivery suite.

As there was no national mandate during the programme, we did not apply a single criterion for assessing triage across inspections. Instead, we judged safety against the trust's own declared criteria for time to first triage and best practice guidelines. For example, we expected to see a rapid review by a midwife for a woman attending the service in an unscheduled way. Proactive services had introduced an electronic safety in triage system to enable consistent professional assessment and recording of the assessment to determine the immediate action needed according to clinical urgency.

Many of our inspections were carried out before the Royal College of Obstetricians and Gynaecologists (RCOG) released its [Good Practice Paper on Maternity Triage](#) in December 2023. The paper acknowledges that implementing the recommendations will require significant system-level change and investment, and a commitment to multidisciplinary working to improve local pathways.

As RCOG's good practice paper points out, maternity triage systems evolved to mitigate against urgent attendances diverting intrapartum teams from caring for people in labour. It highlights, that "unlike general emergency departments, they have developed without appropriate organisational and clinical systems in place to prioritise the clinical urgency of the women presenting". We found this to still be the case.

Triage attendance is not monitored nationally but trusts have told us, using their own data, that they have seen an increase in the number of women who attend the maternity unit with concerns about their pregnancy. While there are many contributory factors, such as access to primary care, or the increase in women with multiple morbidities who become pregnant, a knock-on effect is the additional pressure on triage in maternity services. Sometimes this means services struggle to keep pace with demand and assess people in a timely way.

There is a need for national data collection and analysis about the number of women attending maternity units for triage to monitor themes and trends.

Telephone triage

In the same way that people use NHS 111 when they need general medical help, the first step for women who have a concern or emergency linked to their pregnancy is often to call a triage phone line. RCOG's Good Practice Paper on Maternity Triage recommends that services should have well-defined pathways and dedicated telephone lines where calls are answered promptly. It highlights that telephone triage is complex as there is no clinical assessment, instead it relies on a person's individual account, which can be affected by the person answering the telephone.

Most services inspected operated a dedicated telephone triage service monitored by midwives. We saw pockets of good practice, such as staff trained in telephone triage and measures to ensure lines were monitored. [The improvement resource published along with this report](#) provides more information on the areas of good practice in telephone triage that we identified.

However, as highlighted in [the Staffing section](#), low levels of staffing prevented some services from implementing measures like this. We saw instances where the telephone triage midwife was moved to a busier department, leaving telephone triage unmonitored. This puts women and babies at risk of harm if calls are not answered and means vital early warning signs could be missed. One service did not have a dedicated telephone triage line, which led to a congested main hospital telephone line and delayed women getting through to the telephone triage midwife. On this inspection, we also observed the midwife leaving the phone line unattended and a call was not answered.

We also found services did not always monitor their triage telephone line in terms of the number of calls waiting and call drop-offs to understand the levels of activity. This information could have helped services to gauge the volume of calls to provide enough staff to manage the phone lines accordingly.

At one service that did monitor call numbers and waiting times, we were encouraged to see that data on abandoned calls was reviewed on a weekly basis. More information on this can be found in [our improvement resource](#).

We also saw some services using a paper-based triage prioritisation tool. This was far less reliable, resulting in inconsistencies and confusion between staff while increasing the risk of poor outcomes for women.

Through our Give feedback on care service we heard how issues with the telephone triage line can affect women:

“The triage phone line was not working properly, but it was not clear whether any staff were available to talk to. Because of this I was delayed in going to the hospital in person. When I arrived at the hospital (I went as I had concerns about my baby) I waited 107 minutes before I was seen. It turned out my baby was in distress so I had to have a cat 1 emergency c section delivering my baby at 34 weeks.”

“The initial phone call was helpful and provided advice and told to ring when contractions closer together. Tried to call at this point when I was scared, worried and also bleeding and not knowing what I was doing. Unable to get through for over 30mins. When I did get through I was told that despite having close together contractions that they didn't sound bad enough and that I needed to wait until they were toe-curling and couldn't talk through them (again as a first time mum you don't know what to expect).”

We know that calls to triage are often time-sensitive and calls going unanswered, or lines being frequently engaged could present a real risk to the safety of mothers and their babies.

In-person triage

On arrival at a maternity unit, face-to-face triage is carried out according to a trust's own policy. RCOG's Good Practice Paper on Maternity Triage recommends that a brief assessment is performed by a midwife within 15 minutes of arrival. Then, staff should determine the urgency in which people need to be seen in a standardised way. This assessment should ensure consistency in the way different midwives assess risk and should include physiological assessment using a modified early obstetric or maternal early warning score.

There are a number of tools available for identifying and monitoring risk including:

- BSOTS – Birmingham Symptom-Specific Obstetric Triage System (recommended in the RCOG's Good Practice Paper)
- MEOWS - Modified Early Obstetric Warning Score
- RAG - Red Amber Green
- SBAR - Situation, Background, Assessment, Recommendation.

Like telephone triage, we found similar variation in how services operated in-person triage services. Some services had effective processes and were able to triage a high rate of women within the RCOG-recommended 15-minute guideline. This usually involved staff using a recognised tool for evaluating risk and prioritisation of women, which was reviewed regularly. As we discuss in the sections on [staffing](#) and [estates](#), services with effective triage systems had adequate staffing levels and space to manage flow of people into the service.

Several services did not routinely complete risk assessments on arrival and did not use formal tools or processes to effectively triage women. In one service, it was not clear how long people had been waiting, and in others, ineffective tools and processes led to delays in accessing care. We frequently found gaps in risk assessments and examples of poor record-keeping, which could pose risks for women.

Another service had a chaotic environment, where triage systems and processes were not well managed, which led to long delays. It was also concerning to visit services where staff had access to a risk assessment tool but did not always use it. On one inspection, staff did not always record a priority score, meaning the service could not be assured that all staff had enough information on high risk women and babies.

In a couple of services a RAG system was used to understand women's immediate needs, but the tool did not give target timescales for medical staff to review. At one of these services, there were no processes or guidelines in place to aid prioritisation and ensure women were seen and treated in a timely way, meaning staff had to use their clinical judgement to do this.

Triage environment

The environment is an important factor in the safe and effective running of a triage service. [Health Technical Memorandum](#) guidance outlines that maternity units should be designed to ensure a clear flow of women through triage and onto the labour ward. The location of the triage area should enable quick transfers in an emergency. Good maternity triage areas provide space for people to discuss concerns in private, as well as allowing birthing partners and families to stay while assessments are carried out.

We found that many maternity triage areas had dedicated rooms and areas that gave people privacy for initial assessments, but not all triage environments were designed in a way that kept women safe. While we found one example of a service improving its triage area to ensure safer assessments and improve patient flow (see [our improvement resource](#) for more information), others continued to triage women in areas that were cramped, crowded, and lacked privacy.

At one service, inspectors could hear all information requested and shared during telephone calls. This included identifiable information such as the caller's name and date of birth, and perhaps most worryingly, meant that sensitive information such as safeguarding concerns could not be discussed in confidence. Small triage areas can also cause issues with patient flow. A lack of space for triage had been identified as a risk by many services and was included on their service [\[redacted\]](#) risk register.

The location of the triage area in the hospital itself was another important factor in being able to provide women with safe, high-quality care. For example, having the triage area close to the labour ward enabled quick transfers in an emergency at one service, which helped reduce the risk of poor outcomes related to deterioration. Another trust relocated its triage service closer to the midwifery unit (see [our improvement resource](#) for further information).

We were concerned that in some services, the location of waiting areas posed increased risks to women. Waiting areas out of the direct line of sight of clinical triage staff, for example in a corridor outside a triage unit, meant staff could not carry out continuous observation to identify any deteriorations in condition. We heard how this negatively affected one woman's experience:

“We were left on the corridor in between triage and the delivery suites for 2 hours with no pain relief and nobody checked on us during this time.”

Where women were not in the direct line of sight of clinical staff, we were also concerned about how clinical staff could be summoned in the event of deterioration. At one service, this was compounded by a lack of information for women on how to seek support if their health deteriorated. In another service, while triage was located on the delivery suite, the rapid assessment room was in the midwife-led unit, in a separate area of the maternity unit. This meant the triage midwife would need to leave to go to rapid assessment, leaving other women unattended and increasing their workload.

In some cases, it was extremely concerning to hear about women going into labour and giving birth in maternity triage because of delays in transfer from maternity triage to the delivery suite. As well as putting women in a frightening situation, this poses a safety risk as triage areas may lack appropriate equipment, such as neonatal resuscitation and emergency obstetric equipment. This can be vital if people give birth quickly and experience complications.

Where our inspectors raised concerns about the physical environment and the impact it had on women, leaders in some services acted by submitting improvement plans to try to combat risk and improve the physical triage environment. However, we were also told in some cases there was little more that could be done because of the physical constraints of the estate.

Triage staffing

During our inspections we saw how the availability of staff played a significant role in how well services were able to triage women. The Royal College of Obstetricians and Gynaecologists (RCOG) states that maternity triage should be staffed by “appropriately trained midwifery staff whose primary responsibility is to assess women both by telephone and in-person”. In many services, we found a dedicated team of suitably trained and competent midwives. However, issues with workforce management and staffing numbers contributed to delays in women’s assessment and treatment, which could put them at risk of harm.

When women arrived at triage, many services did not have enough midwives to carry out initial assessments, which led to an increase in the length of time people waited to be triaged. In some services, this affected the flow of women coming through the triage service, as well as increasing the risk of deterioration.

In some cases, delays in triage were so severe that women discharged themselves before being seen by a midwife or doctor. This is unacceptable – these women clearly had concerns that prompted them to go to hospital, so waiting for long periods (in some cases 6 hours) and leaving before a medical review presents safety risks for both the mother and baby. Concerningly, one service did not have systems and processes in place to follow up women who left the triage unit without a review to ensure they were safe.

We also found that midwives were often re-allocated to different maternity departments during quieter triage periods, which frequently led to delays when triage became busier and they were then a midwife short. At one service, the labour ward co-ordinator was tasked with allocating staff from the delivery suite to work in triage. This meant staffing in triage depended on the activity and acuity on the labour ward. At busy times, the triage service would then be under-staffed, posing a risk to women.

We also found that staffing issues meant that staff who had not received sufficient training in triage filled the roles of experienced and trained staff. For example, at one service staff told us they worked in triage but had not received training on the triage system. We found particular concerns around the availability of appropriately trained doctors. In some cases, the required number of doctors had not been allocated to triage in line with the acuity of patients, and in others, the skills and experience of the doctor on duty did not meet the women's needs (see [the staffing section](#) for other examples where staff were covering for roles that are outside of their training).

We found some positive examples where leaders were supportive of triage-specific training. Triage wait times, as well as compliance with national and local guidelines, were better in these services (see [our improvement resource](#) for further details.)

Staffing levels also meant that the quality of care in triage varied between day and night. There were often fewer members of staff on shift during the night, meaning those working had higher workloads. Concerningly, this could mean that women receiving care in triage during the night did not always receive the same level of care and attention as those being treated during the day. In some services during the night, delivery suite staff who did not have access to the same training as triage midwives were expected to cover the triage telephone. Staff at one service told us there were times when they were alone during night shifts and their duties included answering the telephone, initial triage assessments and providing ongoing care to women.

Issues with triage are unlikely to be overcome by frontline staff alone and there is also a role for national policy to support trust boards and integrated care systems to address inconsistencies in prioritisation and escalation by implementing standardised systems.

We recommend NHS England oversees the performance of maternity triage services to enable trusts to benchmark and improve. This is in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendation to introduce “an agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine.” As outlined by RCOG, metrics should include “staffing requirements, agreed audit standards reported nationally, and frameworks for improvement.”

Inequalities and racism

We remain concerned about the inherent inequalities in access to maternity services, experience and outcomes for women, and the safety risks this presents.

We stressed the ongoing inequity in maternity services in both our [Safety, equity and engagement in maternity services](#) report and our [2022/23 State of Care report](#).

The most recent [MBRRACE-UK data](#), published in January 2024, showed that, compared with women from white ethnic groups, Black women were 2.8 times more likely to die during or up to 6 weeks after pregnancy, and Asian women were 1.7 more times likely to die during the same period. The National Maternity and Perinatal Audit's [report on inequalities](#) highlighted further disparities. It showed that compared with women in white ethnic groups:

- South Asian or Black women were more likely to have babies born early or small for gestational age (SGA)
- Stillbirth rates were high for babies born to women from South Asian and Black ethnic groups and for those in the most deprived areas
- South Asian women are also at higher risk of perineal tears and major obstetric haemorrhage.

The inspection programme highlighted that while some trusts are taking action to address issues with inequality, much more needs to be done to ensure maternity services are accessible and meet people's needs at all stages of pregnancy and birth. Everyone deserves safe care and the inherent inequalities faced by some groups are unacceptable.

We found some evidence of how different units were attempting to reduce the impact of inequalities, but this was not consistent across services. Examples of good practice often focused on:

- mental health support
- support for women who were living in poverty
- awareness and inclusion of ethnic and cultural diversity .

For example, one service introduced several initiatives to address barriers face by the community it served. These included establishing an antenatal and postnatal clinic in a hotel housing asylum seekers and creating communication cards for women who did not speak English as a first language. More examples can be found in [our improvement resource](#).

However, without the right data, it is difficult for trusts to evaluate whether initiatives are driving much needed change. In addition, many of the issues we raise in this report meant some services were operating in crisis mode. While day-to-day issues are important, services must not lose sight of the ongoing systemic issues such as the inequalities that we know can have a significant and unacceptable effect on people's care. Reducing inequalities is imperative in saving lives and preventing harm to people with protected characteristics.

Concerningly, we also found some trusts where both staff and people using the service experienced discrimination because of their ethnic background, or issues associated with having English as a second language or that was not their preferred language.

Women's experience of racism

In our [2022/23 State of Care](#) report, we found that care for people using maternity services was affected by racial stereotypes. This has also been reported in The [FiveXMore Black Maternity Experience Survey](#). During our inspection programme, it was concerning to hear about incidents of racism experienced by women. We heard from people who felt staff were neglectful and rude towards them:

“The problems started when I was moved to the postnatal ward. Staff were racist, rude and couldn't care less. They didn't listen to my concerns as a new mum and were desperate to discharge me even when I told them that my baby had only fed once in 36 hours since birth.”

“One nurse even told me I'm over-reacting after having some concerns over my baby knowing full well, I'm a first time mother, my clothes were all over the floor because I couldn't bend. However, another woman who happened to be White across the room got every help she could get. I feel this was very disheartening because I was there suffering. I believe it was racial abuse. A Black woman on the same ward got the same treatment as me. I felt ignored, neglected and ridiculed.”

These examples are supported by our interviews with midwives and obstetricians from ethnic minority groups. Staff identified an issue around a lack of respect for women from ethnic minority backgrounds, with 'dismissive', 'disrespectful', and 'patronising' used to describe the tone of interactions.

Through the interviews, we heard about the safety implications when women were not supported to understand information or communicate their feelings, needs or questions. These ranged from not having the information they need about their own or their baby's health, to very serious physical and emotional trauma with long-lasting effects.

Failing to hear concerns and respond appropriately can have devastating consequences. As a result of one inspection, we issued a Warning Notice where we had concerns that a Black African woman had not been assessed appropriately despite attending triage multiple times. Sadly, this case resulted in a stillbirth. In another case, a review by the Healthcare Safety Investigation Branch (HSIB, now known as the Maternity and Newborn Safety Investigations or MNSI) into the death of a baby raised concerns that the mother's ethnicity affected the care she received. The mother asked for help but was dismissed.

Equity in access to pain relief during labour and after birth has also been identified as an issue nationally. During our inspection programme, our Medicines Optimisation team held a series of focus groups with maternity leaders and frontline staff across 16 trusts. The aim was to help us understand what trusts were doing to ensure that women from ethnic minority backgrounds had equitable access to pain relief.

We asked how trusts audited people's outcomes and experiences of pain and pain relief. Most did not audit this at all, and in those that did undertake epidural audits, ethnicity was not recorded as part of this.

A study published in [the Journal of the Association of Anaesthetists](#) looked at disparities in the delivery of anaesthetic care between different ethnic groups. A spinal anaesthetic for caesarean birth means the baby is exposed to the lowest amount of medication and the mother can participate in the baby's birth. However, the study found Caribbean (Black or Black British) women were more likely than British White women to be given general anaesthesia for elective and emergency caesarean births (58% and 10% respectively).

Further research is needed to better understand the underlying causes of these disparities to see whether improvements can be made to reduce any inequalities in the different types of pain relief and anaesthesia provided.

A [recent MBRRACE-UK study](#) reported that identifying and responding to language needs was insufficient among women from all ethnic groups, highlighting inconsistent provision of independent interpreters. The research also advised that family members and healthcare staff (who are not employed for their language skills or as interpreters) were inappropriately used instead. As outlined in [the section of this report on communication](#), this is not in line with guidance from the National Institute for Health and Care Excellence (NICE), which states that interpreters should be independent.

Access to interpreting services

English as a second language was also a noticeable theme throughout our inspections. We found various examples where interpreting and translation services were available, including BSL (British Sign Language) interpreting services. The use of these services meant women had relevant information in their first language, or preferred form of communication, so they could make informed and safe choices about their pregnancies and births. We also found examples of services that sent duty of candour letters in the woman's first language after an incident, ensuring that all women and birthing people were adequately informed and involved in the reviewing process of serious incidents.

However, we inspected some services where leaders had made an active decision to keep hospital signage in English only, despite the wide range of languages spoken and understood by women accessing the service. Limited access to relevant information can potentially result in harm to women and babies. We found a service where incidents that were recorded were linked to poor outcomes due to lack of interpreting services. One report also described instances of discrimination, where staff made "inappropriate comments" about women who did not speak English as a first language.

NHS services have a statutory obligation under the Equality Act 2010 to have "due regard" to eliminating discrimination and advancing equality, and access to interpreting services is an important way to deliver this. Good quality interpreting services are also vital for services to meet the regulations covering [person-centred care](#) and [consent to care and treatment](#). Providing high-quality interpretation and translation services is an important part of ensuring that women receive the right care, with informed consent, and have improved health outcomes. All the services we inspected had arrangements to provide interpreting services. However, we have concerns that they had not always considered specific aspects to meet the women's needs.

Staff experiences of racism in maternity services

There is a need for action to proactively support maternity staff from ethnic minority groups to ensure a diverse workforce that is representative of the community it serves. We visited some services where staff felt they were discriminated against because of their race and ethnic backgrounds. Staff at one service told us they felt that they were treated differently because of the colour of their skin and at another service, described episodes of racism.

In this example, even though episodes of racism had been reported, no action had been taken to address the issues, which suggests a poor culture around responding to concerns. Discrimination against staff in minority ethnic groups was linked to episodes of bullying and harassment. At one inspection, this was reflected in the trust-level Workforce Race Equality Standard (WRES) data.

Again, this was supported by our research into the experiences of midwives and obstetricians from ethnic minority groups. Interviewees described feeling “ignored, dismissed or effectively punished by negative treatment” when they spoke up about unfairness. Participants overwhelmingly felt that when they spoke up, issues were “swept under the carpet” or only addressed superficially, with a lack of genuine accountability and organisations adopting a defensive position.

On inspections, we also heard concerns from staff at one trust that job opportunities were not made transparent or equally accessible to all staff, with those from ethnic minority backgrounds feeling less able to access senior and board level roles. Through our research, we heard about midwives from ethnic minority groups whose confidence was undermined when applying for promotions, which is compounded where they do not see people from ethnic minorities in senior roles:

“Being in interviews – it was always, ‘you were very close, you just were not quite there’. If you are having this throughout your career, you start to believe it – you think, maybe I am only suitable for a certain role. And when you lose confidence, you don’t perform as well or you stop aspiring.”

Although examples of such discriminatory behaviour were limited during our inspections, they are completely unacceptable and raise important concerns about the inclusion, dignity, and safety of staff from ethnic minority groups in the workplace. Through interviewing staff in our research, longer-serving staff told us that things had improved over time for staff from ethnic minority groups. But interviewees described a culture in which it is normalised for people from ethnic minority groups to tolerate discrimination from colleagues, such as microaggressions, and not being made to feel like part of the team.

Using demographic data

Research by THIS Institute confirms that people from ethnic minority backgrounds may have distinctive health needs that maternity services do not consistently meet effectively. It is essential that a maternity service understands the needs of its local population to provide everyone with safe and effective care. Demographic data is vital to achieve this. However, there is currently huge variation in the way trusts collect and use demographic data to address health inequalities and access, experiences and outcomes from using their services and evaluate progress in this area. Having a national-level picture, along with guidance that could be tailored at trust level, would allow services to understand the data they have and use the metrics to improve access and outcomes.

Local systems have an important role to play in addressing unwarranted variations in population health. As discussed in our [2022/23 State of Care report](#), systems must work to reduce inequalities in people's access to care, their experiences and outcomes. As part of our new responsibilities to assess whether integrated care systems (ICSs) are meeting the needs of their local populations, we will be looking at whether different parts of the system are working together to achieve this.

Through our maternity inspection programme, we were pleased to find evidence at trust level that some leaders understood how various protected equality characteristics may affect treatment and outcomes for women and babies. This awareness was translated into monitoring outcomes and taking action on the findings and even, in some cases, commissioning research , to make services more responsive and appropriate for people's needs. (See more information on these initiatives in [our improvement resource](#).)

But we remain concerned about a data gap at trust-level, which could be preventing trusts from making improvements. We have previously highlighted the need for services to use ethnicity data to review safety outcomes for women from ethnic minority groups. However, during the programme we saw this did not always happen.

Some managers collected information about ethnicity and other protected equality characteristics to identify themes and trends related to inequalities when reviewing incidents. But there are opportunities to review data relating to people with protected characteristics throughout the maternity pathway – not just when patient safety incidents happen.

By looking at other areas, such as the effectiveness of national approaches to improving outcomes, services would be able to gain insight that may not be available from incident data and ultimately improve outcomes. Without this demographic data, many services had no way to analyse whether national approaches, such as NHS England's [Saving babies' lives](#) requirements, were reaching those most in need of support in their local communities. Applying a blanket approach may not always be effective. The Marmot review recommends that while action should be universal, the scale and intensity should be proportionate to the level of disadvantage, known as 'proportionate universalism'.

As reported by THIS Institute, clinical guidelines and tools used in maternity services are not always sufficiently sensitive to the needs of different groups. To mitigate the risk of discrimination, there may be a need to adapt guidelines and how they are applied. For example, the NHS Race and Health Observatory recently called for new assessments for newborns from ethnic minority backgrounds. It highlighted that the Apgar score – a scoring system to evaluate the health of newborns – was developed based on white European babies, with some guidance referencing that a baby’s skin should be “pink all over.” Applying this guidance to babies from ethnic minority backgrounds can lead to inaccurate assessments and poorer outcomes.

We saw some evidence of services adapting guidelines and processes in this way, but this was not always the case. One service amended triage guidelines to have a low-risk threshold to invite women with English as a second language into the unit for face-to-face triage, recognising that language barriers can make telephone triage services less effective.

Engaging with local communities

The role of a maternity and neonatal voices partnership (MNVP) is to ensure the voices of women are heard, and to communicate back to staff and stakeholders to plan, review and improve local services. Where these relationships worked especially well, services built a relationship with the MNVP that allowed people to have their voices heard by their trust, to drive meaningful change and co-produce services or resources.

However, we previously highlighted in our [Safety, equity and engagement in maternity services](#) report that MNVPs were not always representative of the local community and we are concerned that in some areas, this issue persists. For the partnership to be successful, services must be proactive in gathering feedback from all women who use services. As stated in NHS England guidance, “effective MNVPs will reflect the ethnic diversity of the local population and reach out to seldom heard groups, including those most at risk of experiencing health inequalities, parents with experience of neonatal care, and bereaved families.” It is vital that these services are funded appropriately to enable MNVP chairs to reach those most in need of support.

We also found some examples where the relationships between the MNVP and the maternity service were not as strong as they could have been. To enable the work of the MNVP to be meaningful, there needs to be authentic commitment from leaders within maternity services.

We recommend NHS trusts and integrated care boards:

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.
- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.

Estates

Many maternity services inspected were appropriate for people's needs and kept them safe in line with national guidance, but this was not always the case. Too many maternity units are currently not fit for purpose, lacking space, facilities, and in a small number of cases, the appropriate levels of potentially life-saving equipment.

We are concerned about the serious safety risks this presents for women and babies. Common issues found on inspections included:

- a lack of space to accommodate necessary equipment and meet people's needs
- generally ageing environment and facilities, including issues with temperature and ventilation
- a lack of capacity in theatres
- a lack of adequate bereavement provision.

As well as presenting risks to women, unsuitable maternity environments can make it difficult for staff to provide the level of care they want to deliver. As highlighted by the Royal College of Midwives, a human factors approach can help improve safety in maternity care and is about "making the right thing to do, the easiest thing to do". It identifies a range of factors that affect safety and performance, such as:

- equipment should be easy to use and staff should receive training on how to use it
- noise levels and distractions should be monitored to help create a productive working environment
- working patterns, breaks, staff access to nutrition and hydration should be considered to prevent fatigue.

Research has also highlighted the benefits of shared social spaces, where staff can debrief and decompress after complex clinical situations.

However, as we highlight in this section, we found issues with equipment and ward environments which affected both staff and women using services.

Access to equipment and theatres

It is vital that maternity services have the right amount of equipment, and that all equipment is kept in good condition to maximise outcomes for women and babies. We were therefore concerned to find that a small number of services were missing required equipment, including a shortage of cardiotocograph machines used to measure babies' heart rates. Worryingly, we also found a lack of resuscitation equipment at several trusts. While there are no national guidelines for the number of standard items of resuscitation equipment that should be available, [NICE guidance](#) outlines that all birth settings should have facilities for resuscitation. These issues could have a devastating impact on neonatal and maternal outcomes.

We also issued Warning Notices on some trusts that failed to carry out regular checks on emergency equipment or did not adequately document that equipment had been checked. In addition, at one service we found a lack of clarity among staff about who was responsible for ensuring emergency equipment was safe and ready to use. This meant it was often misplaced or untidy. Conversely, only a few services had invested in replacement programmes for ultrasound scanners, neonatal resuscitaires and cardiotocography equipment to minimise these risks.

We also heard concerns about call bells. Although we found call bells were within easy reach in most maternity services and staff responded quickly when called, in a few services they were not working or only working intermittently. One antenatal ward did not have a call bell system in place. In other instances, we observed staff being slow to respond to buzzers. One person told us about having to verbally call for help when in distress or during an emergency as the call bell had failed and staff did not respond. Another person told us they were not able to reach their call bell with the sides up on their bed.

As well as a lack of equipment in some services, we also found issues with theatre capacity. It is essential that maternity services have access to dedicated operating theatres for planned and emergency caesareans as well as obstetric surgical procedures. All services we inspected had at least one dedicated obstetric theatre located within the maternity department, in line with national guidance. Most services had at least 2 operating theatres dedicated to maternity services, which were available for both planned and emergency caesarean sections as well as obstetric surgical procedures. One service responded to our recommendations made in a previous report by improving and future-proofing its maternity theatre provision.

However, in some cases, maternity theatres were out of use because of concerns about space and infection control. This meant that caesarean sections took place in the main theatre, and women and their partners had to walk through corridors and surgical wards for their procedure.

We found that where services did not have access to at least 2 dedicated maternity theatres, there were significant risks of delays to emergency caesarean sections due to lack of theatre capacity. Some trusts managed this risk by having separate surgical lists in the main hospital theatres for planned caesarean sections, keeping a maternity theatre free for emergencies.

Unsuitable ward environments

Many women told us they were unhappy with the hospital environment. Some concerns related to sensory issues, for example people complained of noisy and sometimes overheated wards. Additionally, we heard about unsuitable spaces for labour and postnatal recovery, as well as a lack of bed space.

Several people told us about uncomfortable ward environments, which were stuffy and unpleasant to be in. Fewer people reported feeling cold, but one person described a negative experience when they were placed in a storage cupboard with their baby because there was no space on the postnatal ward:

After my emergency c-section the ward was full. I was freezing from the operation and me and my baby were wheeled into a storage closet with air conditioning blasting. My baby then became cold and unwell and needed to be put under a lamp once we got into the ward... I became deeply distressed and wanted to leave.

Issues with ventilation or a lack of scavenging systems to remove harmful residual medical gases from the air meant that Entonox (as the trade name for gas and air) could not be used in all birthing rooms at one service. National guidance states that Entonox should be available for pain relief in all settings and our 2022 Maternity survey found it was used by 76% of women.

Through our Give feedback on care service, several women explained how the lack of space on wards affected their experiences. We heard of women in labour being placed in the same ward as postnatal patients, or postnatal patients being placed in a triage area because of a lack of appropriate space:

While being in Ward 9 before having my baby I was on the same ward as women who have had their babies already, which to me is unacceptable. I had bad contractions back then and was in pain which is not ideal for either me or women who've had their babies to be in such an atmosphere. The reason I was there was because there was no space in the labour ward, which is what I was told, and I find that appalling.

Furthermore, like other parts of the NHS, maternity services are under increasing pressure and sometimes there is more demand than a service has capacity for. Maintaining good and efficient flow requires a trust-wide culture of safe and efficient patient care. During some inspections we saw how staff spent time dealing with issues around flow in the maternity service specifically, which were not part of the wider trust's capacity management. We suggest maternity services should be included as part of the whole trust-wide capacity and flow processes so that appropriate skills and support can be obtained, releasing clinical staff to focus on managing clinical risk.

Several maternity services had completed self-harm and ligature assessments within all environments to meet the needs of pregnant women at risk of self-harm. Some services coupled this with further actions aimed at reducing risks that were identified, such as staff training around caring for women at risk of suicide.

National guidance on the design of maternity units stresses the importance of security to protect babies and families. We noted issues related to tailgating, whereby it was possible for people to enter a unit without passing any sort of security clearance by directly following close behind someone who had been admitted, which posed a clear safety risk.

Privacy, dignity and hygiene

The experience of giving birth can leave women feeling at their most vulnerable and it is therefore important that ward environments are set up to protect their privacy and dignity. This includes having easy access to ensuite bathroom facilities. While most services inspected had provision for women to have access to ensuite bathroom facilities during labour and postnatally, we inspected some services with limited access to toilets and showers. Some services lacked ensuite rooms in delivery suites, meaning women had to walk through a ward to use communal toilets and showers during labour.

Issues with ward layouts and a lack of space also meant there was a risk that people could overhear confidential conversations. For example, one service did not have a dedicated space for staff to discuss sensitive issues with women, making it difficult to maintain confidentiality during handovers to the birth centre. As highlighted in [the triage section](#), we found that cramped triage areas also compromised women's privacy.

Women also told us about overcrowded and cramped ward environments, which meant they did not have enough space to get changed or attend to their babies. Some people said that beds were placed very close together on wards, which made it difficult to move around with reduced mobility, and again, made it difficult to have conversations in private. This led us to be concerned that people sometimes found it difficult to get the rest and privacy that they needed during their stay at the hospital.

Many women complained about a lack of hygiene in maternity units. For example, we heard several comments about inadequate toilet and shower facilities. Some of the comments related to unclean and dirty bathrooms, such as blood on the floor that had not been cleaned, or urine samples being left in the toilets. Several people also expressed concern about the hospital's failure to change bed sheets. Some people reported having to lie in blood-stained sheets for hours; in some cases, they said that bed linen was not changed for several days. This is particularly unhygienic, given that they were likely to be still bleeding after giving birth and wished to rest in a clean bed. Lack of bedding was also a concern. In one case, someone was asked to bring their own pillow, as the hospital was under-resourced and could not supply one:

“I had to take my own pillow into theatre for the operation (they asked me to as they had none). This is NOT a reflection on the staff – more on the under-resourced NHS.”

Poor hygiene standards sometimes resulted in a lack of dignity for women, who told us that a hospital's failure to clean facilities meant that partners were sometimes called on to clean up, in the absence of staff, or to help change bed sheets due to understaffing:

“No-one changed the mat on my bed for hours which was soaked in blood, plus no-one changed my sanitary pad at all the whole time I was there. So my husband had to change it, which shouldn't really happen.”

Bereavement provision

Pregnancy loss is devastating for parents. Through the inspection programme, we observed the impact of different ward environments and bereavement provision on this experience. We found a high level of variability in the quality of bereavement suite facilities. Where they were good, refurbishment was often funded by hospital charities or community fundraising.

To reduce the potential for bereaved families encountering or overhearing new and expectant parents, national guidance is clear that families should have a private and comfortable space to grieve their loss. We found that most maternity services had a dedicated space for women and families, often located in a private area away from labour and antenatal wards. Some services had clothing designed for very small babies and cold cots so that parents could spend time with their babies and say goodbye.

However, where bereavement suite facilities were available, they were not always in line with the [National Bereavement Pathway](#) recommendations. For example, we inspected several services whose bereavement suites were not soundproofed. In one case, where the bereavement rooms were in the labour ward, bereaved parents experiencing baby loss were being cared for in the middle of a labour ward surrounded by the sights and sounds of newborn babies. In 2 services, the location of bereavement suites was within antenatal and early pregnancy units, with bereaved and grieving families meeting pregnant women in attendance. The location of these facilities was challenging for grieving women and their families and did not adhere to current national guidelines.

Several people in these situations explained how the negative psychosocial impact of antenatal environments made their experience worse. Numerous people described having to sit in waiting areas with other 'happily' pregnant women as a triggering and traumatic experience. Many women felt that these locations were unsupportive of their loss, further highlighting their emotional pain and adding to the difficulties they were yet to face.

We recommend DHSC:

- Provides additional capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.
- Works with NHS England to ensure that this additional investment is ring-fenced and maternity services receive the investment they need.

Communication

Effective communication is vital to ensure women are supported to make informed decisions and feel listened to if they raise concerns.

[NICE guidance](#) states that services should use clear language, provide timely information and offer regular opportunities for questions. It also highlights the importance of considering people's individual needs and preferences.

In our [2022/23 State of Care report](#), we identified poor communication as an emerging theme from our initial inspections. Now that the programme has finished, we remain concerned that communication is not always good enough, particularly for those with protected characteristics under the Equality Act. Communication is also often the subject of formal complaints received by services, who have a responsibility to ensure all women are given the information they need, in a way they understand it, to make informed decisions and consent to treatment.

Communication challenges

In the feedback we received on inspections and through our Give feedback on care service, negative comments about communication during the maternity pathway outweighed positive comments. Many people told us that a lack of information negatively affected their maternity experiences and sometimes resulted in different birth outcomes than they had envisaged or hoped for:

“Communication should just be better, it would help if the staff remembered that it might be all routine for them, but for patients it's very much a new and potentially traumatic time. And communicating in a sensitive way goes a long way.”

“Nothing was explained to us at all. Everyone we spoke to had traumatic births during this period. We had been warned that they leave you and ignore you completely, which they did. You have to shout to have someone come and look at you, and fight to be heard.”

Many people highlighted poor communication during the antenatal pathway, noting they were not given enough time to ask questions. We also heard that staff did not always provide enough information about the harms and risks associated with their pregnancy. Some of these people told us about how they were made to feel like an inconvenience:

“They honestly made me feel like I was inconveniencing them and they were rushing through patients. They didn't take time to ask if I was OK and explain what ANYTHING meant. One even scared the life out of me by misdiagnosing me, luckily me and my midwife caught the discrepancy and queried it. I feel they speak to me as if I'm incompetent and unable to comprehend and then tell me to forget it and not worry when I ask genuine questions/worries.”

In addition, several people told us they felt “fobbed off” and lost trust in the people caring for them:

“Some of the midwives don't listen to your concerns and you feel like you're always being fobbed off or your concerns aren't being listened to...”

“I asked several times to be examined, to which I was told there was no need! I couldn't even sit down my baby had dropped so low, at 7ish I had a bad bleed so someone finally come and examined me and was told I was 7cm!! I had been saying for hours I was progressing and was fobbed off.”

This feedback is supported by the findings of our [2023 Maternity survey](#), which found a 5-year downward trend for respondents saying they were ‘always’ given the information and explanations they needed while in hospital after the birth. This year's results found 60% of respondents reporting that they ‘always’ received the information and explanations they needed, compared with 65% in 2018.

Communication around induction of labour was a key issue. Inductions are often offered when babies are overdue or if there is a risk to their health. While inductions are becoming more common, it is vital that staff recognise that the process can be difficult for women as some may be disappointed about being induced and the process can be painful. Effective communication therefore plays a key role in shaping the experience.

Inductions are often planned in advance and while it may be medically appropriate for someone to wait to be induced, we found that this is not always explained to women. Some women felt they were given insufficient information to understand the reason for delaying an induction, which increased their anxiety about the consequences for their health and their baby.

On a broader level, a lack of mental health support during the maternity pathway emerged as a theme from our analysis of experiences received through Give feedback on care. Despite a recent focus on perinatal mental health, including in the [NHS Long Term Plan](#), many women felt better communication could have reduced their anxiety. People explained that pregnancy and birth is an overwhelming experience and without clear communication, levels of anxiety can increase. Again, it is important that staff recognise this and care for women in a holistic way to improve the overall experience of having a baby.

Listening to women and families

It is essential that women feel listened to by staff, especially when they are in pain. From April 2024, the first phase of the introduction of Martha's Rule will be implemented in the NHS. This will allow patients and families to request a review if they feel their concerns are not being listened to. In maternity services, it may help women make sure that their concerns are heard, as during the programme, we were concerned to hear about instances where people felt that staff did not listen to their requests for pain relief. In some cases, this resulted in poor pain management during birth.

“The staff weren't listening to my worry of not having pain relief and managing without an epidural with my mental health as well as my physical health. By the time the midwife took me over to the room, my labour was unbearably painful, and I was told that it was too late for the epidural. I gave birth with no pain relief – not even paracetamol and I was very disappointed and frustrated that they didn't listen to me when I knew what my body was going to do.”

“I was not listened to by the healthcare professionals during my labour and they were not managing my pain. I was left for several hours despite asking for help.”

One woman we spoke with felt her concerns about pain may have been dismissed because staff knew she had not given birth before:

“When I first went into labour I contacted [name of hospital] for advice. I contacted them 4 times as I was in agony with the pain but was told to stay at home because it was my first child. I felt I had been stereotyped because it was my first child and didn't know how much pain I would be in. When I eventually arrived at hospital after deciding just to go in because I was in so much pain I was actually 7cm dilated.”

Even when women asked for help to manage their pain, they were sometimes not given the help they asked for. Through our research interviewing midwives and obstetricians from ethnic minority groups, we heard how false beliefs around physical characteristics and symptoms can mean some people are denied pain relief. Interviewees reported hearing racial bias in pain assessment, for example:

“Black women have thicker skin, so they are less likely have a tear after delivery.”

“You are African, you are tough – you don't need pain relief, get on with it.”

Stereotyping and a lack of cultural awareness can significantly affect people's experience of care, as we outline in [the section of this report on inequalities](#).

People whose first language is not English face additional inequalities. Access to and the quality of interpreting services varied and continues to be a theme in patient safety incidents nationally. We found some pockets of good practice, for example in one service, the Non-English-Speaking Team (NEST) hosted an antenatal clinic using translation services with midwifery and consultant support. Home visits could be arranged and information was provided in the woman's first language, allowing people to make the right choice for themselves and their babies.

However, our interviews with midwives and obstetricians from ethnic minority groups highlighted that having poor or no spoken English was associated with worse experiences of care:

“My summary is, if you are White you will get good care. If you are not White but you speak English, it's OK, you will get what you need. If you have poor English – it's going to be the very basic standard.”

This supports the findings of our [Safety, equity and engagement in maternity services report](#). In this, we reported variation in how well maternity services tailored communications and engaged with women whose first language is not English.

[NICE guidance](#) is clear that maternity services should ensure that reliable interpreting services are available when needed and that interpreters should be independent, rather than using a family member or friend.

Interviewees also called for staff to do more to ensure that people understand the information they provide:

“Staff need to be very mindful that you will get people nodding their head but not understanding. And instead of just choosing to accept that, staff need to make sure that they have understood.”

Communication between staff

Multiple studies have shown a link between effective communication and safety in maternity services. Teamwork, co-operation and positive working relationships combined with effective co-ordination are also 2 of the 7 features of safe maternity services identified in research by THIS Institute. Where staff communicated effectively, people told us this had a positive impact on their experience.

“My second midwife [name] was brilliant, I witnessed a team who worked seamlessly together, handing over information about my care which made me feel confident in the continuity of the high standards of care I was receiving.”

On all our inspection visits we reviewed the quality of communication and co-ordination at morning multidisciplinary handover meetings on labour wards. These meetings are critical for staff to understand how to manage current risks across the unit. They are also an opportunity for staff to share learning.

A small number of women explained how poor staff handovers had a detrimental impact on their care – notably access to pain relief:

“The lack of continuity of care was also a contributing factor to my difficult delivery and eventual caesarean. There was little handover between most clinicians during my delivery and no handover between 2 clinicians, this also led to difficulties and unnecessary pain.”

“There was no consistency of care during labour. I had the gel and my contractions were really painful and I could tell that the baby was on the way. The midwife wasn't listening to us and actively put off examination due to a change-over of staff.”

We also heard from several people who had to repeat information about their medical history, or preferences about their care because of a disconnect between staff:

“I saw a different doctor from the diabetic team for every appointment, so I had to tell each one my history.”

“There was also a disconnect between consultants, midwives and obstetricians, all of whom seemed to have a different opinion on induction timings.”

NICE published [guidance](#) on information sharing during the postnatal period. It states that when women are transferring between services, relevant information should be shared between healthcare professionals to support their care.

Informed choice and consent

It is essential that women are clear about the risks and benefits of different birthing choices and treatment options. Staff also need to ensure the language they use is accessible so that women know what to expect when they consent to procedures and examinations. Everyone has a right to physical autonomy and integrity, and good communication is vital in empowering people to make informed decisions about their care.

When we found good examples of communication and information-sharing, women praised clear and transparent explanations from staff, which meant that they were able to make more informed choices:

“My husband said that the day my son was born, the maternity department was very busy but I was completely oblivious to this as not one midwife or doctor made me feel like this, I felt like everyone gave me the time I needed and we were able to discuss

options, ask questions and make plans about our care.”

“I had loads of questions and anxieties regarding pain relief and labour, and they were able to answer all of my questions and made me feel at ease. I felt as though I was in good hands.”

However, this was not always the case. For example, one person told us about feeling a lack of choice about being induced:

“I was induced. It did feel as though I was being ‘told’ that I had to be induced. When I expressed my reluctance for an induction a consultant was sent to speak to me. It would have been more helpful to understand the clinical rationale and risk vs benefits of induction versus waiting. The only explanation I received was that ‘baby is to term and it won’t affect baby being born early’. I felt this could have been explained more thoroughly and would help me to make an informed decision rather than feeling ‘forced’.”

In our interviews with midwives and obstetricians from ethnic minority backgrounds, staff identified other factors, along with language barriers, which can lead to a lack of choice. This included cultural perceptions of authority, where people from some ethnic minority groups may be more inclined (or perceived by staff to be more inclined) to accept the advice of health professionals without questioning it. Concerningly, interviewees also suggested that staff may not always offer choice, because they know they will not be challenged. Perhaps most worryingly, we also heard about perceptions around who is ‘entitled’ to care, and this sometimes affected the level of choice offered.

In our [Safety, equity and engagement in maternity report](#), we found many services had worked together with the Maternity and Neonatal Voices Partnership (MNVP) to engage their local community, including reviewing communications and online content. We were encouraged to see evidence through our inspection programme that this has continued. We found some services worked with local MNVPs to improve informed choice and consent by co-producing information on induction of labour including leaflets and information videos.

Accessing digital maternity records

In line with recommendations in NHS England's 3-year delivery plan most services have adopted digital records and have maternity records apps to enable women to view their records at home. We heard a few positive comments about the functionality of the maternity records apps and how it contributed positively to the maternity experience as people could access their records, store their birth plan and receive reminders about upcoming appointments.

However, a small number of women discussed their frustration with the maternity records app. For example, we heard that when it was not updated, this meant there was insufficient information about their antenatal care and tests. This could lead to miscommunication and anxiety where test results were only communicated through the app if midwives and nurses remembered to release the information:

“The [maternity records app] does not update and let patients know about the care and tests they have received. This left me very anxious during my first few appointments and being pregnant for the first time.”

The use of digital technology is not always inclusive. In our [Safety, equity and engagement in maternity report](#), and through our engagement with MNVPs, Five X More and National Maternity Voices, we heard concerns that reliance on digital technology to engage women and provide them with the information they needed could exclude women who do not have the access to, or skills to use, digital technology.

Staffing

Concerns around staffing in midwifery are not new and have been well publicised. The additional scrutiny of maternity services following high-profile investigations including Shrewsbury and Telford Hospital and East Kent Hospitals has compounded this, with staff feeling pressured to go the extra mile.

In our [2022/23 State of Care report](#), we looked at the impact of pressures on staff on both the maternity workforce and people using services. We highlighted that while people using services appreciated that maternity staff were often doing their best despite being very busy, people often felt they were not a priority and did not get the help they needed.

Throughout our national maternity inspection programme, we have seen staff going above and beyond to provide compassionate care for women and their families under difficult circumstances. Despite this, we continued to find that many women were not receiving safe care because of the pressures on staff. Staff also told us that this meant they were not always able to provide the care they wanted to deliver.

Staffing levels

As the demand for maternity services continues to increase, the staffing levels need to keep pace with the changes to keep women and babies safe. Staffing levels depend on the acuity of individuals and the numbers of women needing care. During the programme, services used Birthrate Plus, a midwifery-specific national tool for calculating staffing levels and recommended numbers of midwives.

Delays in improving levels of staff affects the ability to provide safe, effective care. Pressures on staff, who told us they did not always feel respected or supported, meant that care was sometimes task-focused rather than patient-focused.

To keep people safe and ensure that people receive consistently safe, good quality care, we expect services to ensure there are appropriate staffing levels and skill mix. Through our inspection programme, we found variation in this area. Some services had good oversight of staffing levels. Managers in these services reviewed and adjusted staffing levels and skill mix in line with NHS [best practice, with services often having enough staff with the right qualifications, skills, and experience to keep women safe.](#)

We found that many services had a clear escalation policy to manage staff shortages and reduced bed capacity. This gave managers an awareness and oversight of staffing needs in each service area, so they could provide appropriate cover as necessary. Where managers identified the need for additional staff, members of staff could be moved between service areas, they could access on-call staff or community midwives could be recalled. However, this could affect women's choices, for example, they may need to suspend homebirth services. At one service, it was incredibly concerning to see how redeploying staff left one midwife caring for 13 mothers and babies on the postnatal ward. Following this inspection, we issued a [Warning Notice](#), requiring the trust to make significant improvements.

Staff who were redeployed told us they were often moved to unfamiliar areas, which they felt affected their ability to care for women and their babies. We also heard that there was not always a sense of teamwork between units, which could make redeployment difficult for staff.

We found care was not always person-centred or dignified because of a lack of staff. For example, we heard from women who felt maternity staff were overstretched and overworked:

“It was very obvious at times the staff were under pressure to manage all the patients on the labour ward. I noticed staff being pulled from the postnatal ward to work in other areas.... I felt sorry for them. I've heard from friends who have experienced the same as me. Not enough staff but everyone trying hard.”

“The triage midwife also spent a lot of time out of the room, looking for someone to hand over to, but everyone was in theatres. This meant it was just me and my partner left alone in the room, for long stretches during the birth. The triage midwife came back into the room for the final stage of the birth, but the labour midwife missed it entirely, due to being in theatres with other women. I totally understand that there were other women who needed her more than me, but for me, it felt out of control and unsafe.”

A few services that struggled to maintain safe staffing levels indicated staffing shortages as a primary risk on the risk register. As highlighted in [the section on leadership and culture](#), board-level oversight of key issues such as staffing is vital in enabling leaders to make effective decisions and drive real improvement for women. The importance of board-level oversight was also highlighted in the [final report of the Ockenden review](#), which found that a lack of understanding by the board of issues and concerns resulted in neither effective change nor the development of accountable implementation.

Not having enough staff affected the quality of care they were able to provide and put women at risk. For example, at one service we heard how it was a normal occurrence for induction of labours to be delayed due to staffing issues. In some services, we found women having to wait for long periods for transfer to a labour ward once the induction process had started, and in some cases, there was a lack of effective monitoring during periods of delay. Trusts should be making sure women and their babies are observed closely and that regular assessments are carried out to identify and prioritise those at greatest risk. Where we have found concerns about delayed treatment – including induction of labour – we were clear with trusts that effective oversight of the issue is vital and that all action possible must be taken to mitigate any risk and keep people using the service safe.

Staff acting beyond the scope of their clinical practice

The complexity of maternity care has increased in recent years, with higher numbers of women needing higher levels of care, including high dependency care. As highlighted by the Royal College of Midwives, this demands more of the maternity workforce. Services need staff with the skills and expertise to look after people at each part of the pathway – from antenatal to triage, labour, and postnatally. At every stage, staff play a critical role in ensuring the safety of both mothers and babies, identifying early warning signs and making sure people understand what is happening to them. We know that the number of women with complex medical histories is increasing, which increases risk. In the UK, 1 in 5 pregnant women have multiple pre-existing long-term conditions. Studies have shown that maternal multiple long-term conditions are associated with adverse outcomes. Modern day maternity services have not always kept up with this change.

We were encouraged to see that a number of services, while recognising that midwives provide specialist care, also opted to provide training in high dependency care, which aligns to the [midwifery proficiency standards](#). This enabled women who needed more intensive levels of observation (for example, those who had a postpartum haemorrhage) to stay close to their baby while being treated on the maternity unit.

There are currently no national training requirements for midwives in providing high dependency maternity care, which is defined by RCOG as “an intermediate level of care for pregnant or recently pregnant women where a higher level of observation, monitoring and interventions can be provided than on a ward but not requiring high dependency care/organ support.” This is unlike general nursing, where there are competency packages and recognised training packages to ensure staff are appropriately trained to provide this level of care. While some trusts have intensive care outreach services that can care for women when they have babies, these generally provide advice rather than physical care.

Issues with staffing levels were leading to staff having to perform tasks or cover for roles that are outside of their training and not in line with national guidance. Although services were successful in developing innovative solutions to redeploy staff, in others this put women at risk. For example, we were concerned to see instances of unregistered staff acting as [Surgical First Assistant](#) (SFA) or scrub nurses, without proven competency.

We would expect everyone performing the SFA role to have completed training in line with national guidelines. We questioned if this practice was replicated in other NHS inpatient services, but were told it was unique to maternity. This is concerning, given procedures such as a caesarean section require the same level of skill and competence as any other surgery.

We identified staffing issues across the workforce, and problems were not limited to midwifery staffing. Where there were low numbers of staff, one trust used Foundation Year 1 (FY1) doctors interchangeably with more experienced FY2 doctors. It is important that services recognise that the FY1 training year is designed to enable medical graduates to begin to take supervised responsibility for patient care. They are not interchangeable with FY2 doctors who have developed more independence.

There were also some services who diversified their workforce by recruiting registered nurses to carry out tasks which fall outside of [the protected function of the midwife role](#) which makes it a criminal offence (other than in an emergency or during training) for any person other than a registered midwife or registered medical practitioner to attend to a woman in childbirth. Service leaders need to be assured that these registered nurses are not working outside their scope of practice, and how service delivery and outcomes are monitored in practice.

Training and development

The Health and Social Care Act states that “staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.”

While we saw evidence of good practice, we were concerned that staffing pressures meant midwives and junior doctors sometimes missed out on mandatory training and other learning and development opportunities because of the intensity and inflexibility of their rota. For example, staff discussed not receiving training to use the triage system.

In a number of services we found compliance levels for mandatory training were below the trusts' targets. Not completing mandatory training can negatively affect the safety of women and babies.

In one service, only 39% of staff had completed the Perinatal Institute's growth assessment protocol training, and 51% of all staff groups had completed the fundal height measurement training. This was against the trust target of 90%. The training supports staff in correctly identifying if babies are the expected size against gestational age. At the trust, we saw a number of incidents that demonstrated missed opportunities to identify babies who were small for gestational age.

Worryingly, we saw varying levels of completion rates of maternal and newborn life support training for midwifery staff, with low rates of completion in immediate life support (53%) and newborn life support (56%). This meant service leaders could not be assured all staff were suitably trained to respond to life-saving emergency situations, putting women and babies in their care at an unacceptable risk. In addition, we found a number of examples when staff were unable to describe the process of a birthing pool evacuation in an emergency or locate the necessary equipment.

Some junior doctors told us the intensity of their rota provided them with little or no learning and development opportunities as caring for women took priority. We also found the current workforce challenges meant supervision meetings and annual appraisal meetings were often postponed due to clinical work taking priority.

Junior medical staff told us that the inflexibility of their rota meant they were not always provided with protected or paid time for teaching, including mandatory training, and they felt expected to complete relevant training in their own time.

Staff wellbeing

As reported in our [2022/23 State of Care report](#), high demand and more pressure on services is continuing to affect the health and wellbeing of staff across all areas we inspect. In 2022/23, we continued to see high sickness rates for staff, with a high proportion of staff saying they felt sick as a result of work-related stress.

Throughout the maternity inspection programme, staff absence caused by sickness and other reasons such as maternity leave, has been a key barrier preventing services from reaching full staffing capacity. While many factors can contribute to high rates of staff sickness and absence, we identified some themes including stress, COVID-19-related absence, and short and long-term sickness.

Low staffing numbers because of high sickness rates can put additional pressure on staff who are able to work, contributing to low morale, exhaustion, and increasing the risk of burnout. Many members of staff told us that a lack of breaks and meal breaks was common, especially during night shifts. Some staff told us they felt unable to stop for a break due to safety concerns from staffing levels. We also heard about staff working late and/or working additional unpaid hours to support the safety of women. This is supported by a recent survey by the Royal College of Midwives, which showed that midwives and maternity support workers are working 100,000 unpaid hours a week to support maternity services. In addition, 87% of respondents did not feel their workplace had safe staffing levels.

While staff told us they had identified and reported these issues to managers and leaders, some said they felt their concerns were dismissed and ignored. It was concerning to hear from staff who felt that their job had become harder and that they were “pushed to the brink” and “emotionally exhausted”.

We expect providers to care about and promote the wellbeing of staff to enable them to provide, safe, effective, person-centred care. Some services were taking action to improve how they support staff, for example by introducing wellbeing coaches, employee support services and guidance on managing stress. However, it was not clear on the impact of these strategies on staff absence and sickness levels.

Workforce planning and recruitment

Recruitment and retention of staff remains a chronic issue for maternity services and presents a major national concern. It is vital that services can recruit to maintain safe staffing levels. Staff then need to be supported to carry out their roles with the appropriate levels of training on an ongoing basis.

Retaining staff is perhaps an even greater challenge. Sustainable improvement in this area requires further investment to support the wellbeing of staff, enable them to provide the level of care they want to deliver, and prevent them from being driven away by current pressures.

The Royal College of Midwives (RCM) has warned that staffing is the most important issue, which is placing unacceptable levels of pressure on staff and compromising the safety and quality of care for women. These issues extend to recruiting students to join the profession and there is work to be done to future-proof the maternity workforce, with data from UCAS showing that midwifery applications for June 2024 were at their lowest for more than 6 years.

Throughout our inspection programme, we have continued to see high numbers of vacancies. In some cases, services lacked enough maternity staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and provide the right care and treatment.

NHS Resolution's [Maternity Incentive Scheme](#) is a financial incentive programme that aims to enhance maternity safety within NHS trusts and encourage them to implement essential safety measures. The scheme has numerous requirements for trusts to ensure effective midwifery workforce planning. However, we found some services had not fulfilled these requirements, for example by not following best practice when calculating the midwifery staffing.

Services identified high staff turnover as being associated with a lack of opportunities to progress to other roles. Although staff were promoted at one service, we still found issues with staffing shortages as the service had not replaced midwives it had promoted.

In an attempt to combat some of these issues, in 2022/23, the government announced that all maternity units would be given additional funds to increase supernumerary capacity and improve support for midwives, with a continued focus on retention and pastoral support activities. The majority of units we visited had a recruitment and retention midwife in post, whose role included:

- providing pastoral support to the workforce
- attracting new staff through proactive succession plans to address shortfalls in staff numbers and skills mix
- working with matrons and midwives to identify where improvements could be made to support staff retention.

Some recruitment and retention midwives collated themes from staff exit interviews to drive improvement. At one service, 18 members of staff who planned to leave had been retained as the recruitment midwife had identified what staff need and ensured the availability of clinical development opportunities.

In contrast to staff shortages, several services were found to have low vacancy rates and limited staff turnover, although no reason was provided as to how the service achieved this.

Reporting red flag events

The National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings' describes a midwifery 'red flag' event as "a warning sign that something may be wrong with midwifery staffing" such as delays in medical reviews and maternity triage difficulties. Nearly all the services we inspected reported maternity red flag staffing incidents in line with these guidelines. However, we saw inconsistencies in how these were recorded, monitored and mitigated. We noted that a few services had no red flag incidents within the reporting timeframe.

In addition, it was not always possible to identify in trusts' board papers whether maternity red flags were presented to the board. This could mean that boards were not fully appraised of the safety concerns women were experiencing.

We saw that maternity red flags were primarily associated with delays in care, with most red flag events identified as delays to induction of labour where one-to-one care was unavailable, or staffing or bed availability that was considered to compromise safe infant delivery for women. Some services aimed to prevent future red flag events through a review of planned admissions, enabling transparent conversations about activities within all units and discussing red flag incidents at safety champion and governance meetings to identify themes and learning.

Medical staffing

Reviews by doctors in triage are often compromised because middle grade rotas are hard to fill. The middle grade cover for triage is often (but not always) from the intrapartum team, who will prioritise intrapartum over triage unless the case is very urgent. Often, these doctors are also covering gynaecology emergencies from the emergency department. There is no dedicated national model of obstetric cover.

All units we inspected had adjusted the level of consultant cover to meet the requirements set out in the Ockenden Review recommendation to have 2 ward rounds in a 24-hour period. However, as we highlighted in our [interim blog](#), we are concerned that the cover model is often fragile, and the rotas rely on every consultant being available and establishing a culture of escalation for support. While funding was provided following the Ockenden report, it was not enough to meet the demand from trusts.

We recommend NHS England:

- Has oversight of gaps in middle-grade rotas and the proportion of time spent by consultants covering them. This supports recommendations in the Ockenden Review to introduce nationally agreed minimum levels of medical staff to cover the full range of maternity services at all times.
- Works with the Nursing and Midwifery Council and Royal College of Obstetricians and Gynaecologists to establish a minimum national standard for midwives delivering high dependency maternity care.

We recommend the Royal College of Obstetricians and Gynaecologists takes our findings in relation to the surgical first assistant role in maternity services so that it is in line with the requirements set out by the Royal College of Surgeons.

We recommend that the Nursing and Midwifery Council uses findings from our report to review their proficiency standards for midwives.

Leadership and culture

Effective leadership, governance and culture can drive and improve the delivery of high-quality, person-centred maternity care and help to drive a culture of safety and improvement.

The first [Ockenden review](#) into maternity services at Shrewsbury and Telford Hospital NHS Trust highlighted the need for strengthening leadership and oversight, preventing toxic cultures and fostering more collaborative approaches in maternity services. Similarly, Dr Bill Kirkup identified a culture of denial and described 'a resistance change' in his investigation into maternity failings at East Kent Hospitals University NHS Foundation Trust. To drive meaningful change and address systemic issues, a joined-up approach from organisations, colleges and system leaders is essential.

Our inspection programme supported these findings, demonstrating the importance of strong leadership and an inclusive culture. We found that many of the issues raised in these reviews of individual trusts not only persist but are widespread.

We observed a wide range of maternity service leaders who demonstrated dedication and passion in making their service effective in caring for women and babies, but the quality of leadership remained varied. We identified numerous factors involved in effective leadership, including:

- a stable leadership team, with consideration of succession planning and backfilling to enable seamless provision of services
- leaders with the capacity to support service development, address issues in a timely way and drive continuous improvement
- a detailed understanding of immediate issues and priorities faced by the service to form the basis of an effective management plan
- a leadership team that is accountable for acting on risks identified and making tangible improvements
- supportive and approachable leaders who listen to staff and act on what they hear in a way that the workforce recognises
- regular and clear communication and transparency from leaders.

In his report into failings at East Kent, Dr Bill Kirkup highlighted “the divergence of objectives of different groups” as an issue that is particularly striking in maternity care. He highlighted a “struggle for ‘ownership’ of maternity care” where “rather than contributing as equal partners, midwives may be encouraged to see themselves as being ‘there for women’, defending them from the ‘medicalisation’ of maternity care” and putting them in conflict with obstetricians. We saw one instance of a team not working holistically, which we escalated to the trust leadership team when identified and issued a Warning Notice to drive urgent action.

In maternity services, it is vital that multidisciplinary teams work towards the same aim – safe care for women and babies throughout the maternity pathway. As previously seen in the East Kent report, divisions within professions can place women at a greater risk of harm.

Culture

An open and positive culture can demonstrate examples of teamwork, professionalism, and listening to women. Healthy cultures, where staff feel supported and empowered to thrive, improve staff retention and are crucial to ensuring high-quality, safe care for people.

We expect leaders at all levels to understand the context in which they deliver care, treatment and support, and to embody the cultures and values of their organisation. They should have the skills, knowledge, experience and credibility to lead effectively, with integrity, openness and honesty. Good leadership is vital in creating an inclusive team culture with effective communication, escalation and clear routes of accountability. This is necessary for good clinical care for women and helps to drive a culture of safety and improvement.

In our [Safety, equity and engagement in maternity services](#) report, we found variation in the culture of services we inspected. There was evidence of poor working relationships between obstetric and midwifery teams in some services, staff did not always feel valued, and some services could not demonstrate a clear culture of learning.

Throughout our inspection programme, we were encouraged to find examples of leaders taking responsibility for providing a safe service, often seeking external support and guidance and being open to scrutiny at all levels. However, more work is needed to ensure these cultural values are present in every service.

In many maternity services, we observed a positive, just and learning culture of reporting incidents and near-misses, with staff encouraged to raise concerns without fear. For example, one service shared regular newsletters and posters of 'you said we did' with staff and patient feedback from recent visits from non-executive directors. This is vitally important, as a poor culture can mean staff do not feel confident to speak up and issues can become exacerbated. A positive culture is also marked by the quality of interpersonal relationships in a service. We were encouraged to visit multiple services where staff reported feeling respected, supported and valued by their colleagues. More examples can be found in [our improvement resource](#).

Unfortunately, not all services demonstrated these values. For example, at one service, staff spoke of low morale and described a blame culture, where managers did not listen to their concerns. We are concerned that while these cultures persist, services will not be able to address issues raised in reports such as the Ockenden review, and ultimately, families will continue to suffer. We heard that a decline in enthusiasm, burnout and low morale were having a negative impact on culture.

As highlighted in [the section of this report on inequalities](#), staff feeling ignored or dismissed emerged as a theme in our interviews with midwives and obstetricians from ethnic minority backgrounds. When staff do not feel empowered to speak up, or their concerns are dismissed it can be indicative of a [closed culture](#), in which people are more at risk of deliberate or unintentional harm. Any service that delivers care can have a closed culture and we monitor for signs or risk factors associated with closed cultures throughout our inspection activity.

Some trusts recognised that they needed to address cultural issues. For example, one trust that had recently been through significant structure changes made sure staff had a common purpose of providing safe, quality maternity care.

Throughout our inspection programme we came across leaders at all levels who challenged our findings. We heard from some leaders that our inspection reports were contributing to poor morale among maternity staff, making it even more challenging to recruit. In contrast, we heard from staff who wanted to share their experiences, and in some cases thanked us for going into their services and highlighting areas for improvement.

There is no doubt that maternity services receive a great deal of publicity and much of that describes poor experiences and, at times, devastating outcomes. Some women told us they are frightened of what might happen if things go wrong. This is unacceptable.

We heard an overwhelming message from trusts' maternity leaders that they did not want any more recommendations on what they need to do to improve. However, as our report highlights, on a national level there are some fundamentals of care that need systemic improvement. Until these are addressed, women and babies will not consistently receive the level of safe care they should be entitled to and the level of care that staff want to be able to deliver every time.

Visibility of leaders

In our [Safety, equity and engagement in maternity services](#) report, we previously raised concerns about a lack of clear, consistent and visible leadership. When we assess whether services are well-led, we expect leaders at every level to be visible and lead by example, modelling inclusive behaviours. This can help make staff feel supported in their role and enable them to escalate concerns promptly to improve outcomes for women and their babies.

We were encouraged to see examples of visible leadership on many inspections, which are outlined in [our improvement resource](#). Several trusts benefitted from the use of maternity safety champions. These were introduced as part of the [Safer maternity care action plan](#), where maternity clinical networks were asked to designate a maternity safety champion to promote learning, seek out best practice and share it across the system. At one service, the board safety champion ran regular open forums both virtually and in the maternity unit to gather feedback from staff and listen to their concerns or queries. They were regularly visible and approachable on the wards, taking a proactive stance in maintaining and improving standards of care.

However, on several occasions, we heard about leaders who were not always visible. At one trust this meant that not being present prevented them from recognising the scale of issues the service faced. Here, safety champions had limited, superficial knowledge of the service and executive leaders failed to recognise the severity of issues faced within maternity. The impact of this lack of oversight and visibility was clear on our inspection – the delivery suite was chaotic and not having clear organisation or leadership hindered a calm and systematic way of working.

Information sharing

Information sharing is paramount for safe and effective care. Without it, leaders may be hampered in their ability to make effective decisions. At ward-level, when caring for women, it is essential that staff communicate well, especially during handovers, to make sure they are aware of potential risks and can deliver compassionate care.

Throughout the programme, we saw examples of good information sharing between staff and managers, but we are concerned that leaders do not always have a full picture of their service and may miss opportunities to learn. At one hospital, there were clear communication systems for sharing information from ward level to service managers, who were routinely available to respond to any issues. In addition, meeting minutes and information on notice boards displayed positive feedback to staff.

Another service had a risk and governance midwife who was responsible for sharing learning from incidents. At a different service, sharing information was an important element in safeguarding training and included examples of harm, how incidents were reported in the trust, and actions that had been taken as a result.

Reporting incidents is key to providing leaders with a clear picture of their service. Although we saw evidence of trust boards being presented with incident data, this was usually limited to incidents graded moderate and above. Given the potential issues with the grading of incidents outlined in [the safety section](#), we are concerned that trust boards may not have the full picture of maternity incidents, themes and trends. This presents a missed opportunity for boards to check and challenge, and limits the ability of services to learn and improve.

In addition, we found no regional or local oversight of incidents reported and graded by perinatal services. NHS England regional midwifery teams, integrated care boards (ICBs) and local maternity and neonatal systems (LMNS) do not have access to the NRLS data set. Again, this could mean a missed opportunity for analysing trends, identifying inequalities and benchmarking at a local or national level.

Leadership decision-making

Clear oversight of challenges enables leaders to identify issues, make effective decisions and drive meaningful change. While we saw evidence of strong leadership and good decision-making at several trusts, we also found examples of poor decision-making and issues with vacancies within leadership teams.

One service exemplified how effective leadership, governance and culture can drive and improve the delivery of high-quality, person-centred care. Here, staff at all levels demonstrated commitment to sharing data and using information proactively to drive internal decision making as well as system-wide working and improvement. Another service had a clearly defined management and leadership structure, led by a triumvirate comprising a divisional director, midwifery director, and associate medical director for obstetrics, gynaecology and neonatology. This helped leaders to make effective decisions based on a clear understanding of the challenges faced by the service.

However, we also saw instances of poor decision-making, which was sometimes compounded by a lack of leadership support and communication. For example, a small number of services did not always collect and analyse reliable data, which meant they were unable to make effective decisions and drive improvements. We also saw evidence of a lack of decision-making where, following a period of instability within the leadership structure across the trust, a number of senior posts remained vacant. This led to delays in implementing improvements.

Leadership vacancies for maternity services are a problem. We saw a high turnover of staff in senior leadership roles in some trusts. We could also correlate this with our ratings of the well-led key question. Maternity services usually have a head of midwifery and/or a separate director of midwifery who reports to the trust's chief nurse. In addition, there are maternity leadership roles in ICBs, NHS England's regional teams and other bodies such as MNSI, and NHS Resolution. Some midwives expressed concern that there was only a finite pool of capable leaders, which makes recruiting for these posts challenging. While there is no doubt maternity services need leaders who understand the complexities of delivering a safe maternity service, there may be a further argument to explore the greater need for effective, strong compassionate leaders, supported by maternity experts.

Leadership response to staff concerns

The [final report of the Ockenden review](#) highlighted that many members of staff reported a fear of speaking out as well as a culture of 'them and us' between midwifery and obstetric staff. As we previously raised in our [Safety, equity and engagement in maternity services](#) report, the result of this is 'working in a silo', which can have a hugely detrimental impact on women, particularly when concerns need to be escalated. During the inspection programme, although we found some good examples of leaders engaging with staff about their concerns, this was not always the case. Where there was a failure to listen and respond to issues about safety, this put women and babies at risk of preventable harm.

But it was encouraging to see instances of leaders being responsive to concerns. This included holding listening events, displaying 'you said, we did' posters and at one service, having non-executive directors undertake regular safety walkabouts to give staff an opportunity to voice concerns.

A key component of an open culture is creating an environment where staff feel supported to raise concerns. We were pleased to see many members of staff feeling able to speak to leaders about difficult issues and incidents. Issues were raised through a number of routes, including [Freedom to Speak Up](#) teams, guardians or ambassadors, who supported staff when they wished to voice their concerns.

However, on a small number of inspections we found that while some staff felt that they could speak up when they needed to, not all of them felt that leaders always listened to them or felt confident that the organisation would address their concerns. This could contribute to a poorer culture where staff are deterred from raising concerns in the future, and ultimately opportunities to improve care may be missed.

At another service, we were concerned to hear that staff had raised issues directly to senior leaders several times regarding safety and staffing levels, but did not see the quick action or improvement they had expected. A similar picture emerged at another service, where we heard there was sometimes unkindness between staff and that following incidents, leaders did not provide compassion and support.

Governance

Effective governance structures support the flow of information from frontline staff to senior managers and trust boards, ensuring leaders have the insight needed to make effective decisions and vital improvements. While some of the services we inspected had clear and established governance processes in place, this varied between trusts. Without effective governance processes, leaders do not have oversight of the risks and issues in maternity services and cannot address them in a timely way.

In a small number of services with limited oversight at board level, opportunities to address issues were missed. This meant, for example, that leaders only heard about the impact of an understaffed triage and delays in medical care when staff raised concerns, rather than regularly monitoring key areas on an ongoing basis using performance metrics. A review of board papers for 7 NHS trusts by the Sands and Tommy's Policy Unit raised questions over the ability of boards to fully understand the performance of maternity units. It highlighted a need to step back and reflect on metrics over a longer timeframe, as well as ensuring sufficient time for meaningful scrutiny.

While some trusts had well-established maternity governance teams, in other services, the teams were under-resourced. This was sometimes because of staffing pressures and the need to redeploy governance teams to provide frontline care. There are further opportunities to explore the skill mix within governance teams and make use of generalist risk and governance expertise when required. At times, we found an over-reliance on using midwives rather than recognising the different benefits that a non-maternity team member who is trained in the fundamentals of governance and risk can contribute.

Many of the concerns we identify in this report are about the fundamentals of safe care and treatment and are similar to the requirements in any other healthcare service.

Vision and strategy

It is vital that leaders ensure there is a shared strategy, and that staff understand and support the vision, values and strategic goals. Staff need to be clear on how their role helps in achieving these goals and be motivated to work towards them. Where staff had the opportunity to develop the strategy at a local level, this resulted in an engaged and motivated workforce, with staff who not only understood the service's vision and how to apply it to their roles, but were also able to explain the vision to women.

In a small number of services, we were concerned to find an absence of a maternity-specific vision and strategy, or that the overall trust vision and values did not include maternity services. The nature of maternity care means that attempting to apply broad visions of principles is likely to be an ineffective approach and could fail to recognise the unique position of women using maternity services. Having a specific maternity strategy helps staff ensure their services are responsive, evidence-based, and sustainable. In a minority of cases, although services had a strategy, they failed to communicate it well to staff, meaning they were prevented from understanding how their work contributed to the wider vision.

Gathering feedback and handling complaints

As a regulator, we believe people using care services, their carers, families, friends and advocates are the best sources of evidence about their lived experiences of care, and we champion this in our work. We are also clear about our expectation of services: providers should make it easy for people to share feedback or raise complaints about their care, treatment and support.

In several services, we were encouraged to see how staff effectively handled feedback from their investigation of incidents, both internal and external to the service. At one service, the governance midwife collated feedback to identify themes or trends related to health inequalities and included these in staff training and feedback sessions. At several other services, staff knew how to acknowledge complaints and women received a response from managers after the investigation into their complaint.

Conversely, in a smaller number of services, feedback was not handled as well. For example, at one service, there was limited evidence that changes had been made following feedback. At a different service, we were concerned to hear that senior staff sometimes took several months to review feedback, with staff reporting limited meaningful action and improvement following feedback. A lack of serious consideration of feedback or delay in taking action presents a missed opportunity for trusts to make vital improvements at an earlier stage of risk of harm and increases the likelihood of mistakes being repeated.

We urge system leaders to prioritise improvements in maternity services, both from a cultural and financial perspective, to drive much-needed change.

We recommend NHS England ensures trusts are proactively managing succession planning in midwifery services, and, in line with recommendations from [Leadership for a collaborative and inclusive future](#) review, supports midwifery and obstetric staff to become effective future leaders.

Evaluation of the programme

As part of our work, we commissioned The Healthcare Improvement Studies Institute (THIS Institute) at University of Cambridge, with RAND Europe to evaluate our inspection programme and to identify where we can improve.

The evaluation had 2 objectives:

- to characterise what good safety culture looks like in maternity services and the factors underpinning it
- to evaluate the national maternity inspection programme to maximise learning.

Here, we look at the findings from the programme evaluation.

THIS Institute interviewed CQC inspectors, staff managing the programme and staff from inspected provider organisations (23 interviews in total). They also reviewed internal and external programme documents, including anonymised inspection notes, and undertook a literature review of the evidence for regulation with a particular focus on inspection.

Key findings from the evaluation include:

- The programme ensured that maternity remains a high priority in NHS trusts and gave greater momentum to current improvement initiatives.
- Our focus on equality and diversity further highlighted these issues in maternity settings. Although inspectors were keen to include these considerations in their inspections, the focus was brought in later in the programme. Therefore, assessment materials were not always designed in a way that made it easy for inspectors to consistently capture relevant information.

- The programme placed demands on maternity services, which sometimes struggled to provide the information we requested at short notice ahead of inspections. Our inspection visits were perceived to add to already high levels of scrutiny from regulatory and quasi-regulatory bodies.
- The scale of issues identified on inspection meant that the process was more involved than had been anticipated – both for services and for CQC colleagues. The programme was planned and delivered very quickly, which also introduced challenges.
- Some staff in maternity services said they were uncertain about the effectiveness of the inspection process, which made them question the consistency and validity of the ratings produced in some cases. Staff told us this was partly because of how they perceived the inspectors used discretion when making judgements, and that they felt the reasoning behind judgements was not always made transparent. Some staff also shared that including inspectors in the programme who had less direct maternity expertise and experience might have resulted in judgements they felt to be less robust.

Following the evaluation and feedback from inspectors, we are exploring what changes we can make to improve inspections of maternity services.

The role of inspection

The National Maternity Inspection Programme used inspection as the primary tool for gathering evidence. The evaluation therefore focused on the role of inspection as an effective regulatory tool.

From the evidence reviewed, the evaluation reported general agreement that inspection is a vital part of effective and accurate regulation, since some aspects of quality, safety, culture and leadership are difficult to assess through secondary sources. To gather enough evidence across the wide range of factors that contribute to high-quality care, inspections need to use methods that look at specific and observable activities as well as more complex features such as culture, vision and innovation.

The evaluation highlights the benefits of principle-based inspection, rather than inspection that is based on the use of strict rules and prescriptive standards. Principle-based inspection allows inspected organisations to respond to regulators in flexible, adaptive, and reasonable ways. It empowers professionals to take ownership while also supporting inspectors to exercise discretion. However, in applying discretion, the consistency of inspections may be challenged.

Going forward, inspections will remain an important part of how we regulate. Since delivering the National Maternity Inspection Programme, we have moved to our new assessment approach. As part of this approach, we'll gather evidence to support our judgements in a variety of ways and at different times – not just through on-site inspections. This means inspections will support this activity, rather than being our primary way to collect evidence. We know that observational methods, such as inspection, have a clear role in capturing evidence about cultures in care settings. The findings from the National Maternity Inspection Programme presented in this report suggest there is a clear need to continue to use inspection as part of our assessment of maternity settings.

The learning from the evaluation has given us helpful principles to consider when delivering inspections. This includes how we might use additional checks and balances to review judgements made by inspectors.

Learning opportunities

In addition to considerations for how we undertake inspection activity well, the evaluation has helped shape the following learning opportunities:

- Improve the alignment with other oversight bodies, including those who provide improvement support, to reduce demands on services. This can include careful consideration of the scheduling of visits and timing of information requests. It could also involve timely data sharing between us and other bodies to enable comprehensive judgements of risk that tell the whole story.
- Identify opportunities to use data that is specific to maternity services and distinct from data at trust level to help us delve deeper into risks and issues in a more targeted way. This will help us with our continuous monitoring of risk and reduce the scale of issues uncovered in inspection.
- Continue to improve how we assess equality and diversity in maternity settings to ensure this remains a central focus and key priority for services. This can include improving internal processes and systems for evidence gathering of specific equality and diversity information.
- Focus on building trust and positive relationships with maternity settings to encourage regulation to be seen as a factor that contributes to improvement. Positive feedback from inspected trusts as part of the programme welcomed kindness from inspectors and a thoughtful and supportive approach.
- Share more information with providers due to be inspected as part of focused programmes to create shared expectations and improved awareness of the information we will be reviewing.
- Improve how we plan focused programmes to ensure there is sufficient time to provide further learning and development opportunities to inspectors who have less experience in specialised settings and to ensure we can secure the involvement of specialist advisors.

Despite the challenges, regulation remains critical in maintaining safe levels of care and driving improvements in sectors like maternity, where we know systemic issues persist. We have a clear role in outlining the quality of care that people should expect and holding services to account if they fail to meet these standards. Learning from this evaluation will help us to carry out this role in the future.

© Care Quality Commission