Department of Health & Social Care

NHS England

A National Programme to make Maternity and Neonatal Care Safer For All

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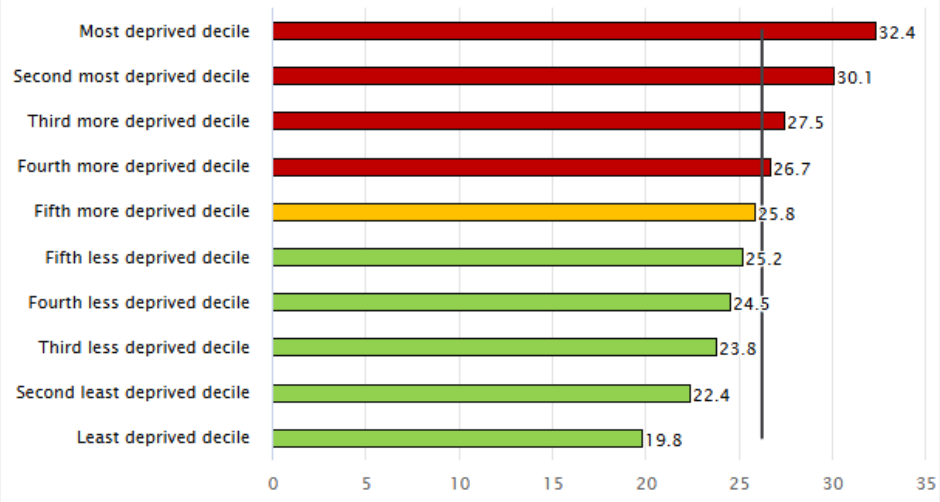
1. Demographic changes

Demographic changes

Demographic changes

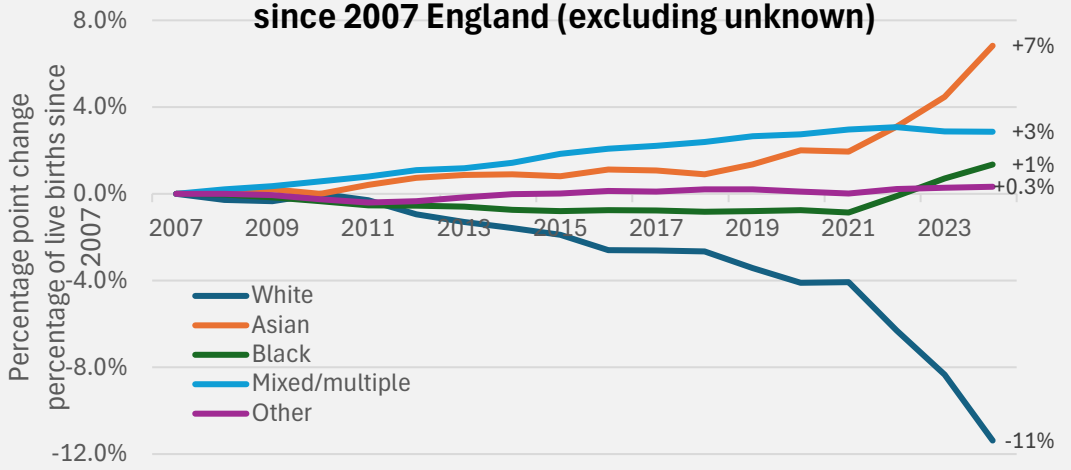
The profile of women using maternity services has changed significantly in the last 10-20 years. Women now tend to be older, with a higher BMI and more likely to have been born overseas.

Obesity in early pregnancy by deprivation, England, 2023-24



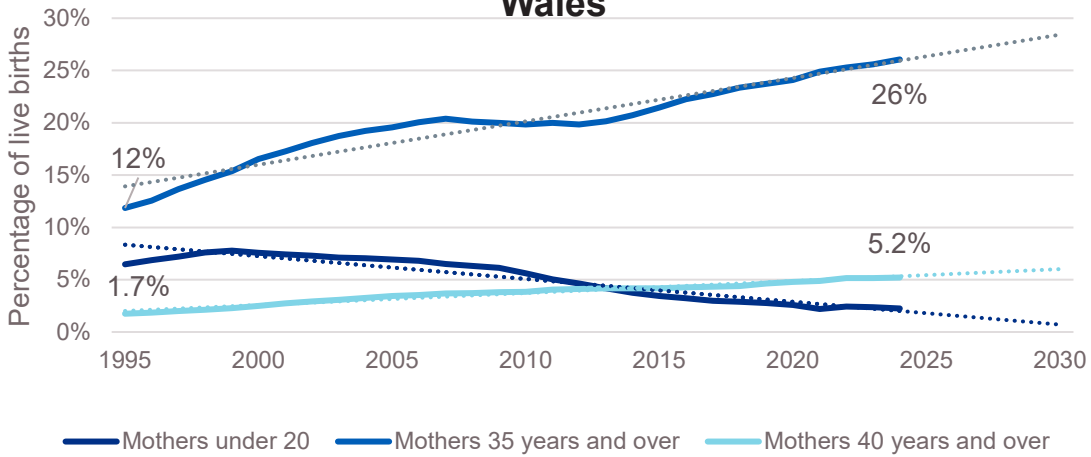
The proportion of pregnant women who were overweight or obese in early pregnancy increased from 50% in 2018-19 (28% overweight, 22% obese) to 59% in 2023-24 (30%, 26% respectively).

Percentage point change in live births by ethnic group since 2007 England (excluding unknown)



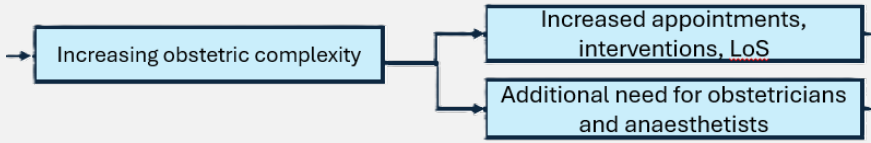
In 2024, one or both parents were born outside the UK for 40% of live births in England

Live births by women's age group, England and Wales

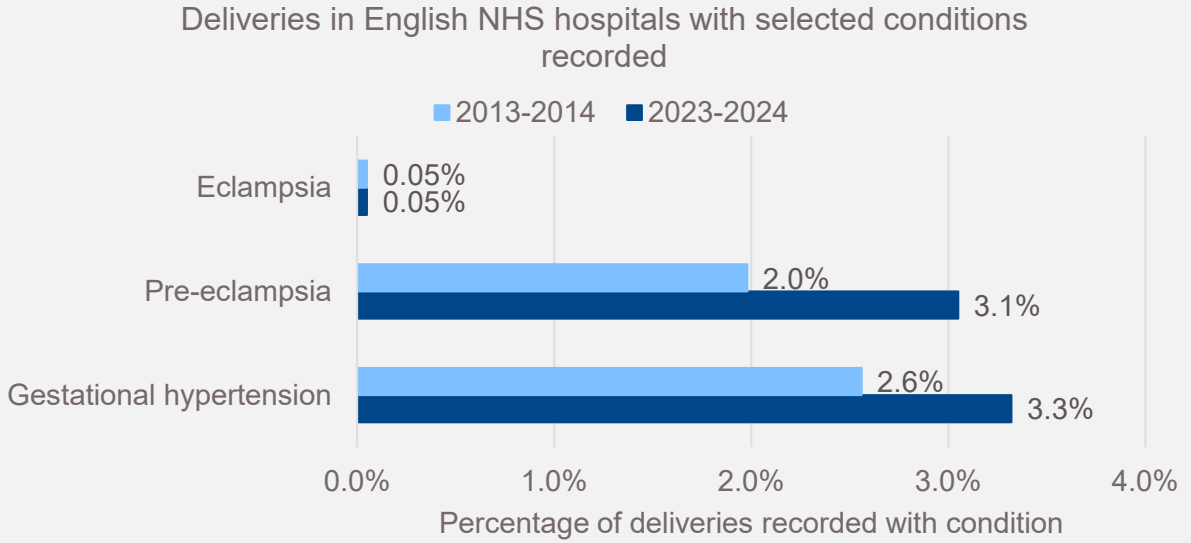


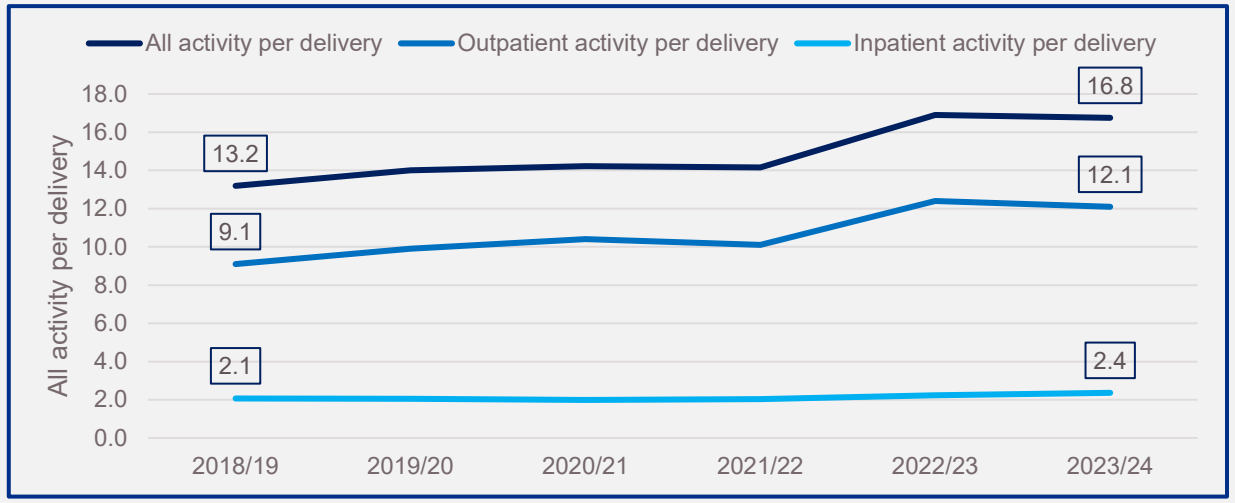
The percentage of live births to women aged 35 years and over has doubled since 1995 and will reach 29% by 2030 if this trend continues linearly.

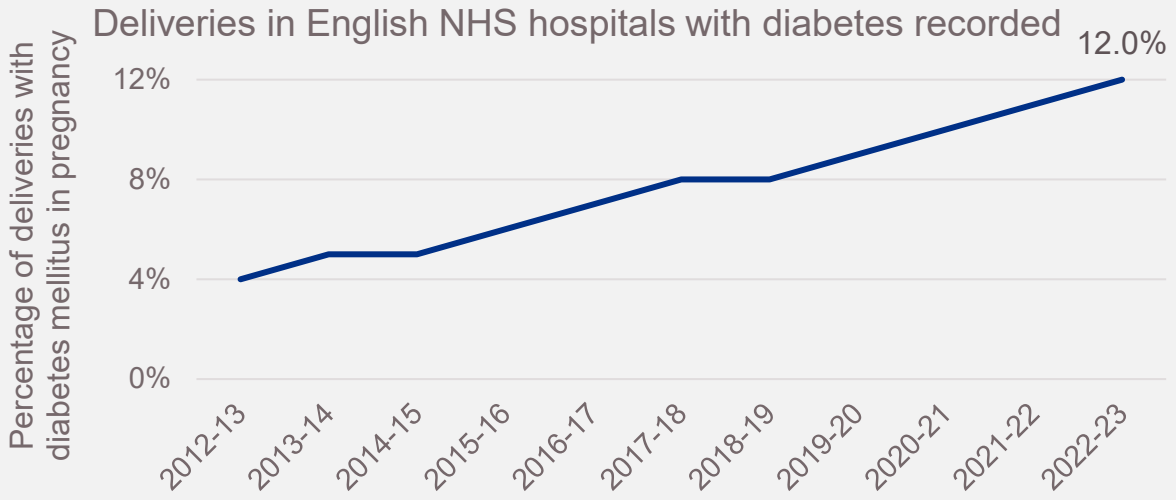
Obstetric complexity / demand



- Increased maternal complexity creates a requirement for:
  - Additional antenatal appointments
  - Higher likelihood of interventions at birth (e.g. induction, caesarean)
  - Additional need for midwives, obstetricians, theatres, anaesthetics and neonatal cots
- Although births have declined, activity per birth has increased
- Costs of maternity care have risen, The direct cost to the NHS of a complex birth is around three times a non-complex birth







Estates

The CQC National Review of maternity services in England 2022 – 2024 found “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.”[1]

Funding from the 2025 Spending Review may address immediate infrastructure risks such as leaking roofs and electrical faults, but will not address increased bed days and requirement for additional theatre capacity driven by rising complexity.

Current trends for increasing use of interventions during births (e.g. inductions and caesarean sections) suggest the need for a significant increase in bed days by 2029-30 leading with a particular pressure on certain parts of the estate such as theatre capacity.

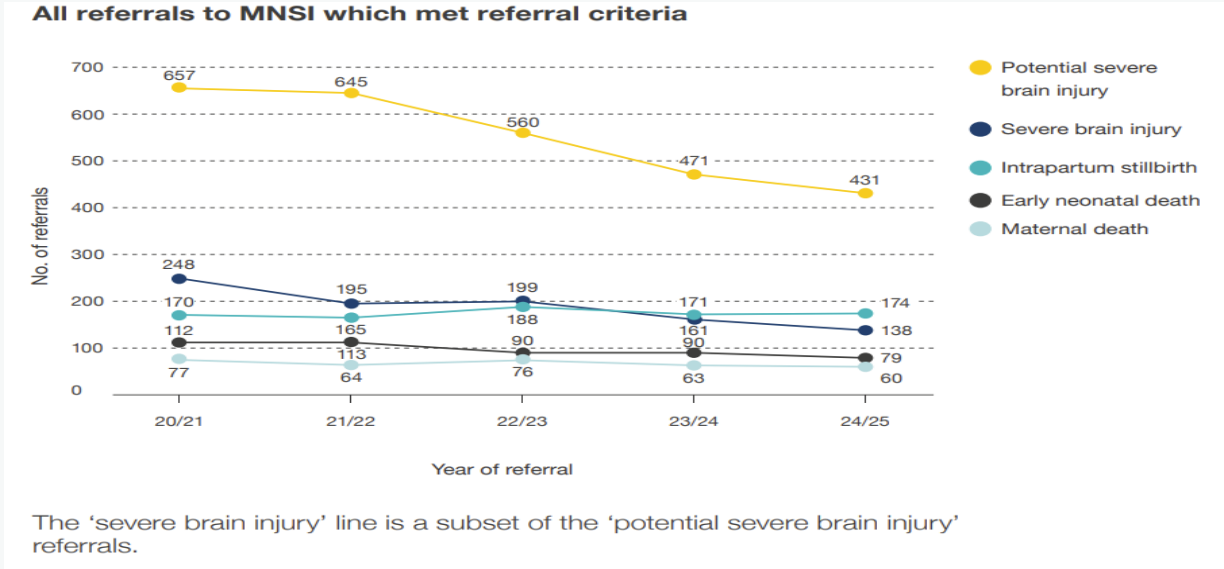
Improvements across key outcomes: stillbirth, neonatal deaths, pre-term births and, potentially, brain injury. Maternal mortality has not show desired improvements

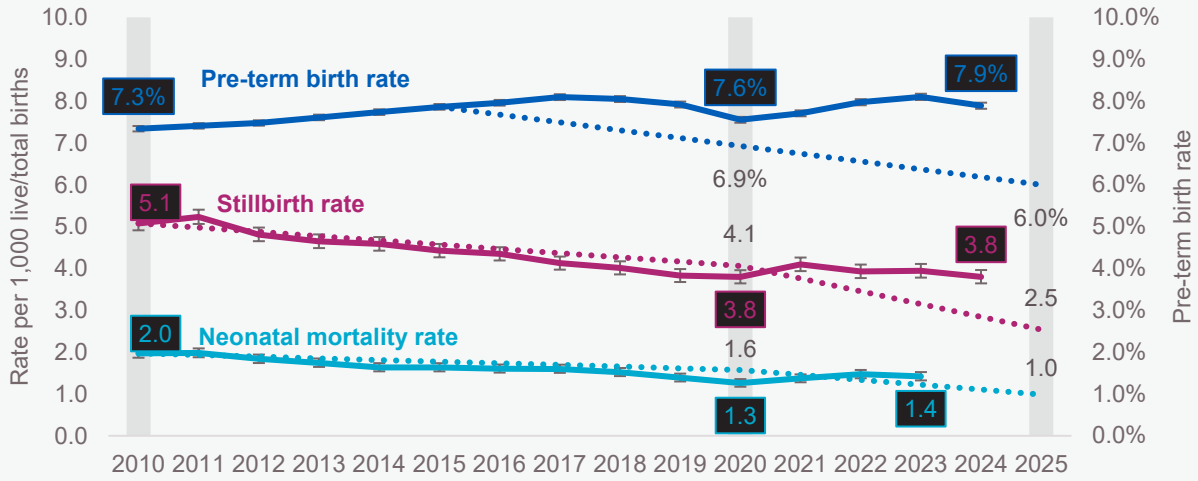
Stillbirth rate: The stillbirth rate for England has dropped from 3.9 per 1,000 births in 2023 to 3.8 per 1,000 births in 2024 (2,182 stillbirths in 2024, a 25% lower rate than 2010).

Neonatal mortality rate: Following 799 neonatal deaths in 2023 (at 24 weeks plus gestational age), the neonatal mortality rate dropped from 1.5 per 1,000 live births in 2022 to 1.4 in 2023. This represents a decrease of 27.7% compared to the 2010 baseline.

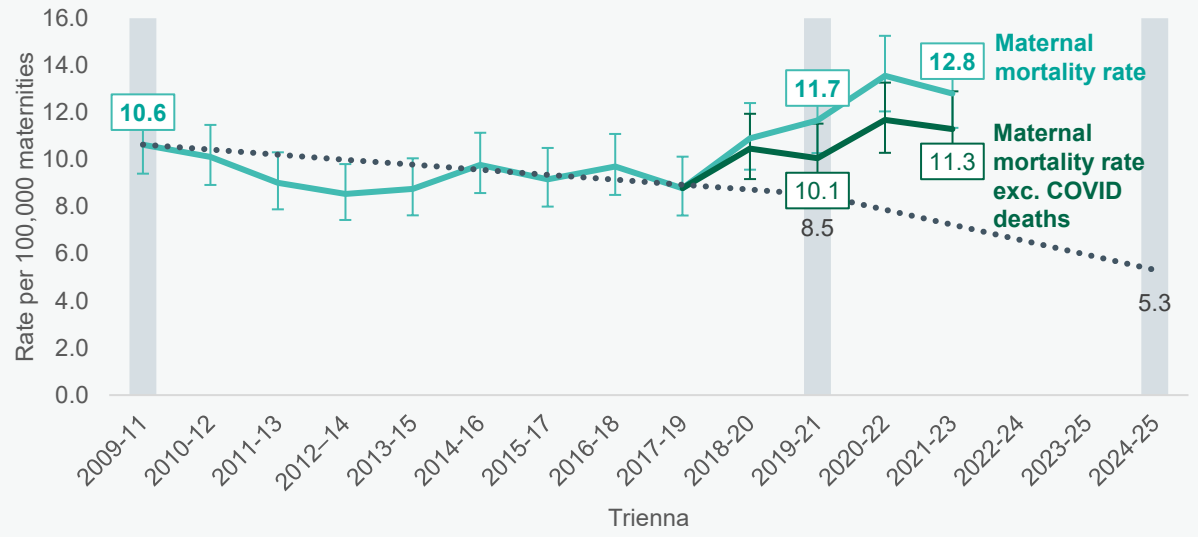
Pre-term birth rate*: The preterm birth rate dropped from 8.1% in 2023 to 7.9% in 2024, the first reduction since 2020. There were 44,798 pre-term births in 2024.

Brain injury rate: There were 4.2 brain injuries per 1,000 live births in 2021, the same as the previous year, but 11% lower than the peak in 2014 (4.7 per 1,000 live births). The 2021 rate of brain injuries for term babies was 2.5, a reduction of 19% compared to the peak of 3.0 in 2014. The 2021 pre-term rate was 25.6, similar to 25.3 in 2014 however, referrals to for brain injury have fallen by 33% since 2021/22 suggesting a reduction in harm.





Maternal mortality rate:** There were 257 maternal deaths in 2021-2023. With 30 Covid deaths excluded, the rate was 11.3 per 100,000 maternities, down from 11.7 in 2020-2022.



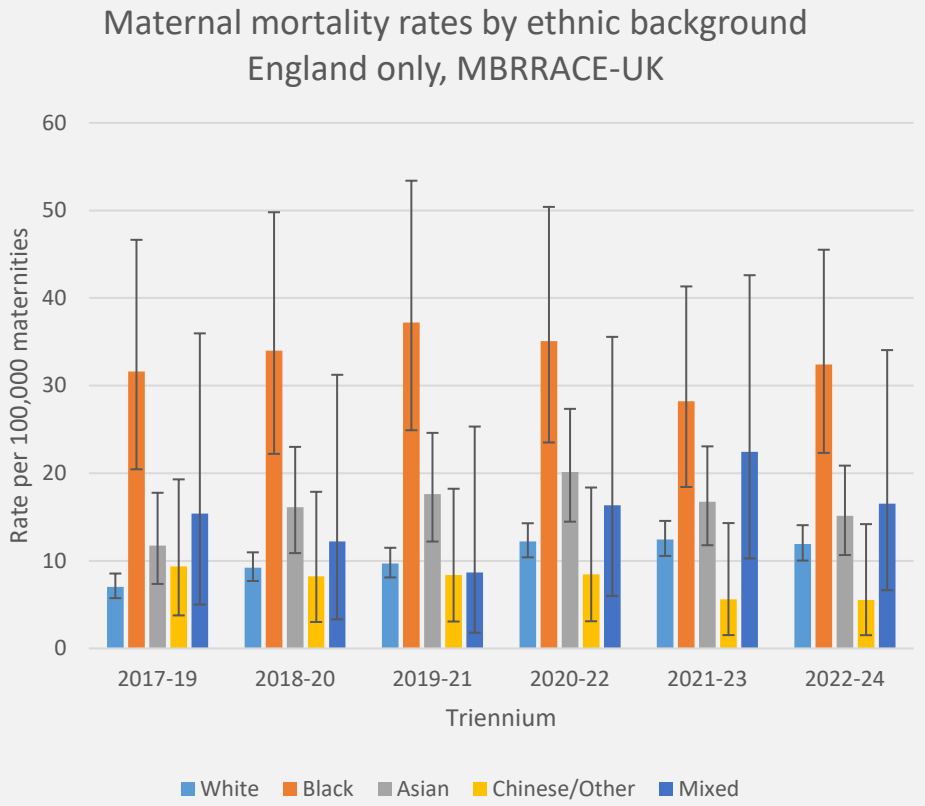
-Source: National Ambition level monitoring using ONS data for stillbirths, neonatal deaths, and pre-term births. Maternal mortality uses MBRRACE-UK. Data lags arise from registration delays, dataset linkage and case-by-case validation, with small numbers making accuracy vital. Timeliness is improving through faster annual releases, and ONS is now piloting quarterly stillbirth data.

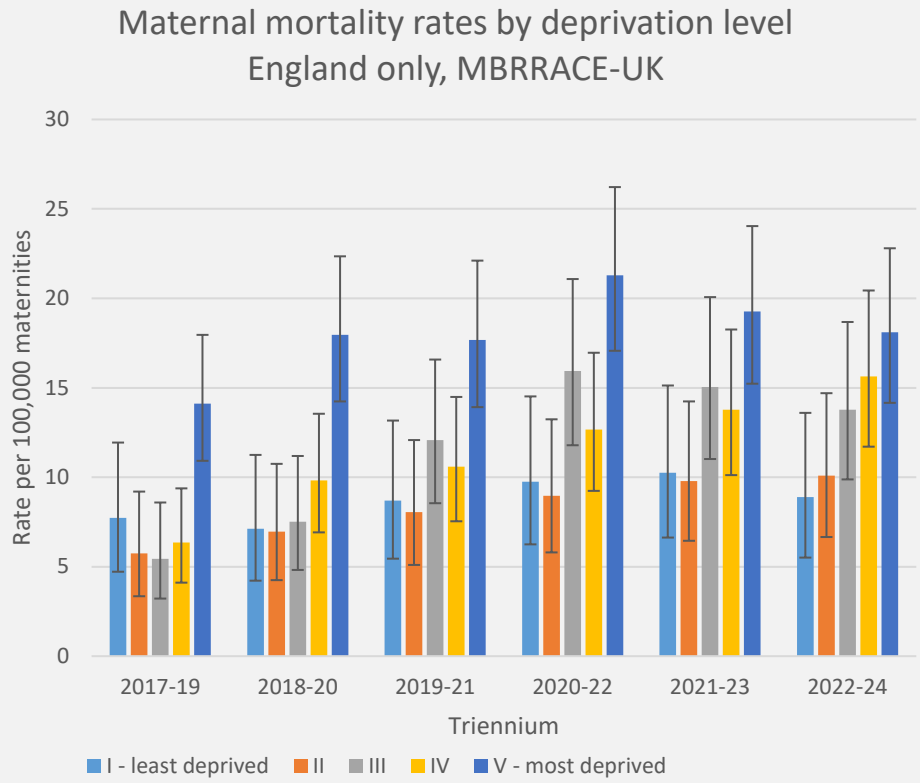
Inequalities in Maternal outcomes persist across ethnicity and deprivation

Maternal mortality: 2021-2024

Ethnicity: There remains an almost three-fold difference in maternal mortality rates for Black women (32.42) compared to White women (11.93). Asian women (15.14) and women from Mixed ethnic backgrounds (16.53) were higher compared to White women.

Deprivation: Women living in the most deprived areas continue to have a maternal mortality rate (18.1) twice that of women living in the least deprived areas (8.9).





Demographic changes

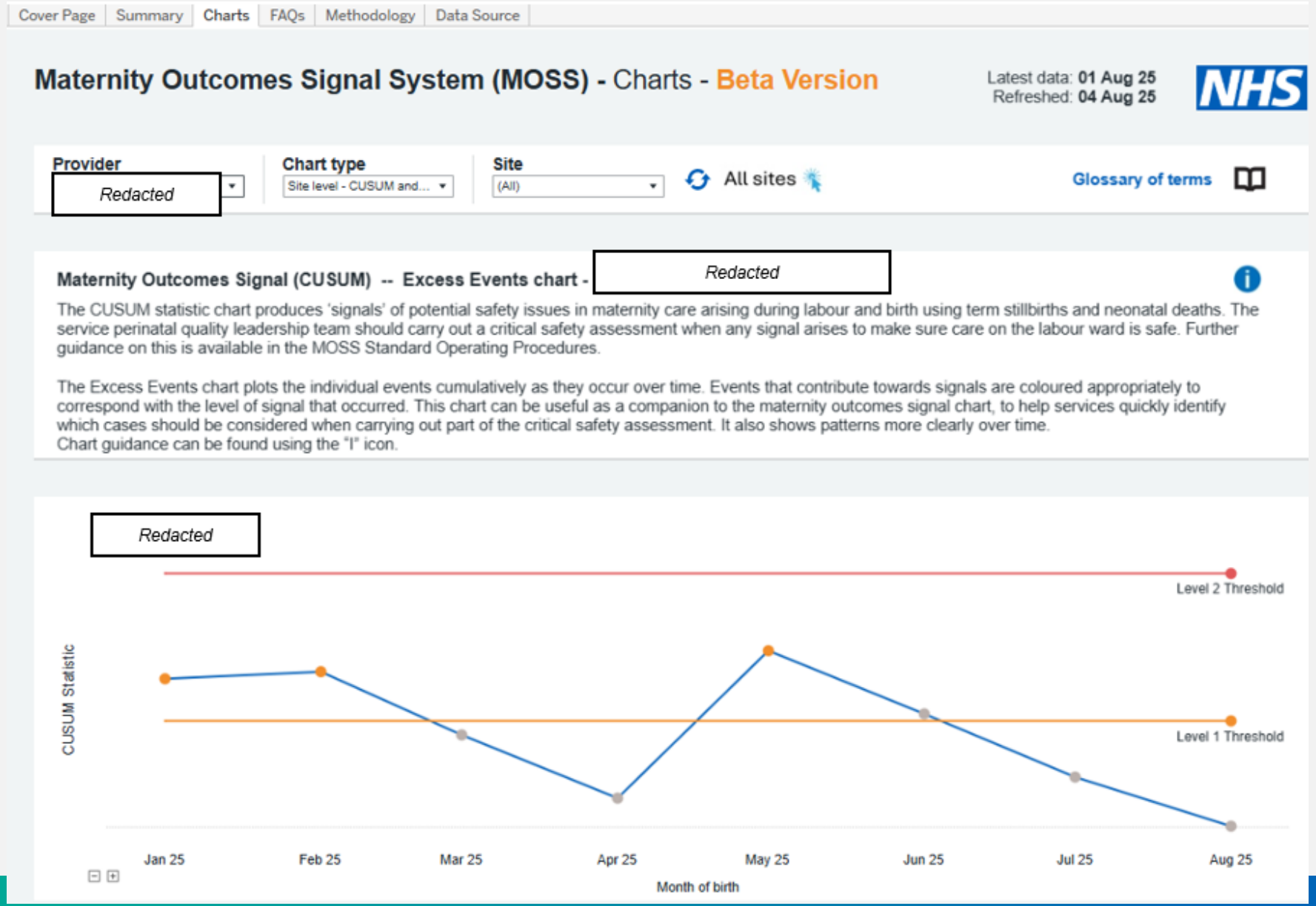
What have we done?

- Completion of the **Three-Year Delivery Plan for maternity and neonatal services** Including ensuring women have access to maternal medicine networks, pelvic health services and perinatal mental health services.
- **Maternity Outcomes Signal System**–detect & address safety concerns earlier
- **Saving Babies' Lives Care Bundle**–reduces mortality and morbidity though 6 elements
- Roll out of **Enhanced Midwifery Continuity of Carer**
- Estates review

Work in progress

- Implementation of **Maternal Care bundle:** cross system action to address the 5 highest causes of maternal mortality
- **Avoiding Brain Injury in Childbirth (ABC):** Improving clinical management of two significant contributors to avoidable brain injury in childbirth: detection and response to suspected intrapartum fetal deterioration and management of the obstetric emergency of impacted foetal head at caesarean birth. *From January 2026*
- **Postnatal Care Improvement Toolkit:** Supporting systems to take a joined-up approach to postnatal care across maternity, health visiting and primary care, with a focus on continuity, safety and reducing unwarranted variation in outcomes. *Published January 2026*
- Implementation of **Triage Specification**

MOSS signals – CUSUM Chart



What have we learnt from SBLCB?

- High levels compliance
- Well -received by most staff
- Evaluation notes decrease in stillbirths but increase in interventions
- Variation in practice remains a challenge
- Too many audits/data requests
- Move from focus on process to outcomes that matter to women
- Creating environment to support improvement work
- Board level visibility essential

Moving away from existing silos

The required improvements in Maternity and Neonatal care can only be made by working across the NHS.

The maternal care bundle addresses the top 5 reasons for maternal mortality, and the top 4 require joint work with other parts of the NHS:

Element 1, Thrombosis in early pregnancy
joint working with primary care
Element 2: Pre-hospital and acute care
Implementation of MEWS across all settings where a pregnant, or recently pregnant woman might present and shared pathways across ambulance, ED and maternity services
Element 3: Epilepsy in pregnancy
joint working with neurology services
Element 4: Maternal mental health
Joint working with mental health services

Changes to workplace culture, ensuring the right environment for staff to speak up, listening to patients, addressing inequalities, racism and discrimination within services cannot be confined to one or two service areas within a hospital.

Workforce

2. Workforce

We are reducing workforce gaps, but there is more to do

Staffing is a key concern for maternity and neonatal services. NHS Staff Survey 2023 results show that midwives report more work-related pressure than other NHS staff. The select committee and Donna Ockenden recommended increasing funding by up to £350m/year. Additional NHSE investment of £186m/year has helped reduce workforce gaps.

- **Midwives:** As of Mar 2024, there were 1,333 FTE more Midwives substantively employed compared to Mar 2023. Vacancies are down to 6.3%, with leavers and turnover also improved.
- **Obstetric consultants**: Mar 24, 98 FTE more consultants reported than Mar 23. The vacancy rate is 6.4% (Source PWR- unofficial MI).
- **Neonatal nurses:** Since the beginning of 2022/23, an additional 548 WTE neonatal nurse posts recruited to.

Staff morale

Repeated investigations into maternity failings and intensive scrutiny has had a negative impact on the professions of midwifery and obstetrics, and on individual staff.

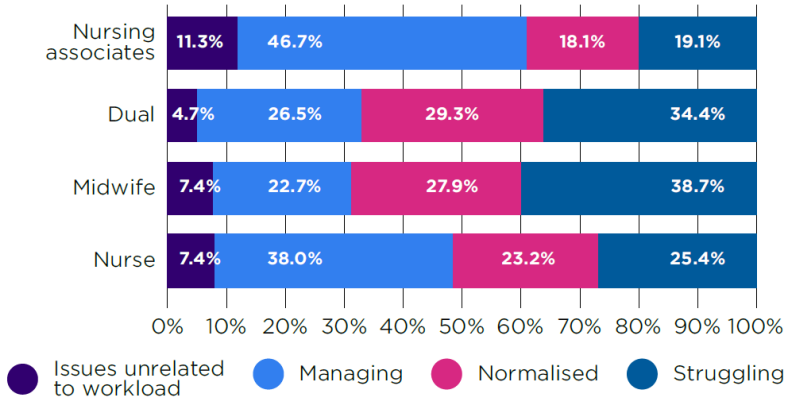
2024 Staff survey scores for midwives were all lower than both the national and nursing & midwifery average. The largest gap is in 'We are safe and healthy' theme.

*A recent workforce spotlight survey from the Nursing and Midwifery council showed that midwives were more likely to be struggling with their workload than other professions.**

Reflections and initial Impressions from the Amos review reports

	2024 National average	RN&M	Midwives
We are safe and healthy	6.14	**5.87**	**5.25**

Figure 28: Proportion of professionals coping with workload by profession



Workforce

What have we done?

- Publication of **Core Competency Framework**
- **Perinatal culture and leadership programme**: offered to all maternity and neonatal leadership teams. This included a diagnosis of local culture and practical support to nurture culture and leadership.
- **Submit a Perinatal Event Notification (SPEN)** portal: Making it easier for services to report adverse events in a timely way through digitising and streamlining reporting processes and removing duplication. Launched September 2025.

Work in Progress

- **Maternity & Neonatal Improvement Support Team**: Support trusts to develop diagnostic and improvement plans, based on regional heat map metrics and regional intelligence and will include a focus on tackling inequalities and hearing and responding to service user feedback effectively.
- **Optimum obstetric staffing Principles:** developed with RCOG to fix the additional asks on obstetric time.
- **Leadership Descriptors:** to describe what is needed to provide high quality maternity leadership

PERINATAL CULTURE AND LEADERSHIP DEVELOPMENT PROGRAMME TIMELINE

NHS England

practive

KORN FERRY
BE MORE THAN

1 QUAD LEADERSHIP DEVELOPMENT

A 6 month programme comprising:

- Welcome event
- 3 modules (face-to-face)
- 4 action learning sets (3 virtual, 1 f-2-f)
- Leadership perspectives (self directed strengths based facilitated 360)

2 CULTURE SURVEY

A 3 - 4 month process covering:

- Identifying local champions to support culture survey and debrief process
- Mapping
- Going live with the survey
- 6 week 'live' period
- Results

3 CULTURAL CONVERSATIONS

A 4 - 5 month process comprising:

- Quad development sessions
- Team conversations
- Quad check-ins
- Improvement planning

YOUR SELF-ORGANISATION

- Continue meetings and conversations as Quad and with Board Safety Champions
- Peer support from action learning set
- Continue conversations about culture in your teams
- Continue working on improvement priorities
- Provision of practical support / tools for teams and leaders to use when planning improvement

What have we learnt?

- Quad relationships improved; with instances of improved teamworking and cross service collaboration.
- Leadership development was valued. Quad teams felt able to be ‘braver’ in addressing issues proactively.
- Evidence of cultural change was limited; this is due in part to some of the timeframes but also the operational challenges / structural support required for sustainability, e.g. maternity and neonatal being in separate divisions and tensions across multi-site Trusts.
- Staff engagement beyond the quad was inconsistent. Some reported greater staff engagement and a positive cultural shift towards openness, but this was not consistent.
- Structural barriers (e.g. staffing, silos, lack of time) were major obstacles to engagement, participation and ultimately, impact. Services in crisis, quad capacity, disengaged boards/ lack of Trust support all played a part.

Women’s experience

3. Women’s experience of care

Women's Experience of Care

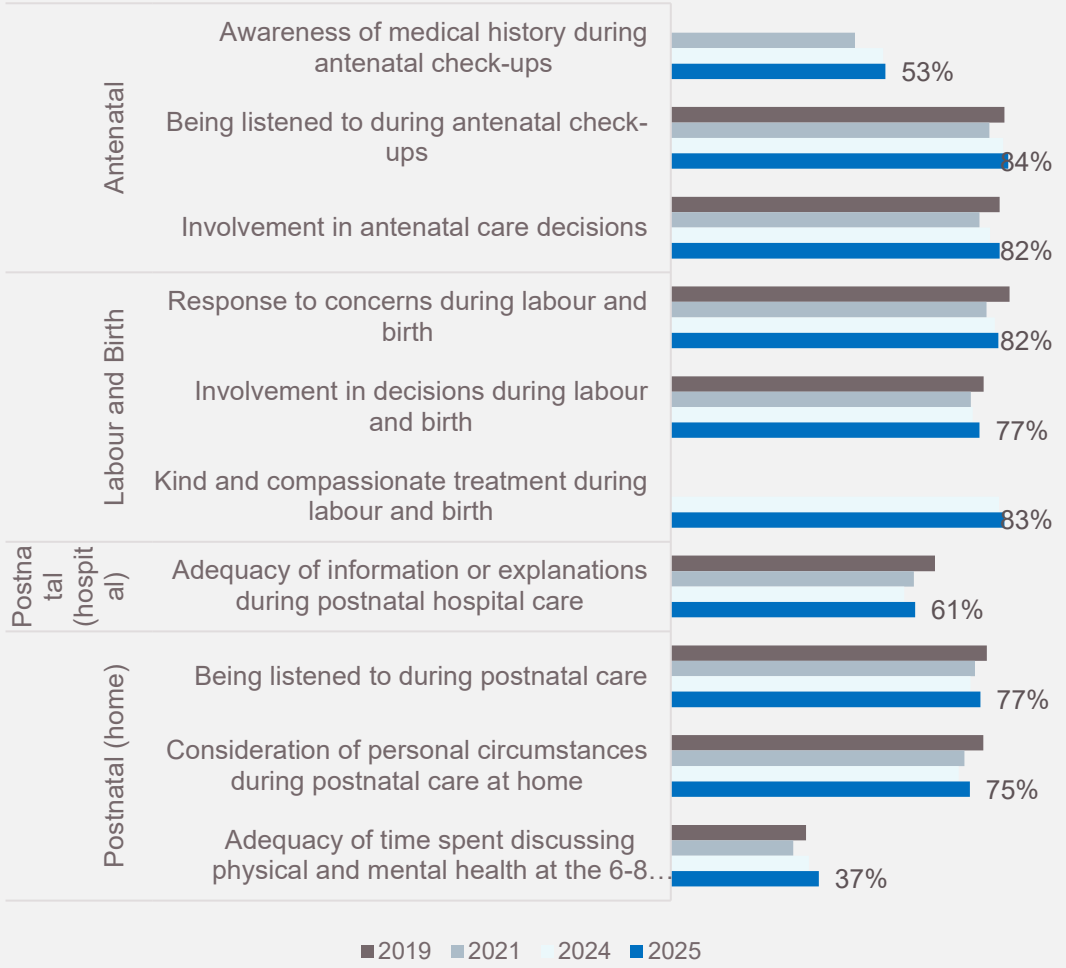
Results from the 2025 CQC survey show that nearly all questions demonstrated statistically significant improvements compared with 2024, and the majority of results now have improving trends over the past 5-years

Poorer experiences are also apparent, for example, 24% of respondents felt that they were left along during labour at a time that worried them; 13% felt that health professionals did not do all they could to help them to manage pain relief during labour

We continue to hear from individual families who have had very poor experiences that were not addressed appropriately by the Trust concerned. Care provision in the context of where harm has occurred is also very varied.

A key priority is amplifying the voices of service users, which depends on having well-supported and effective local maternity and neonatal voice partnerships (MNVPs) as committed to in the three year delivery plan

3 Year Delivery Plan measures of personalised care taken from the CQC survey, showing improvement over time



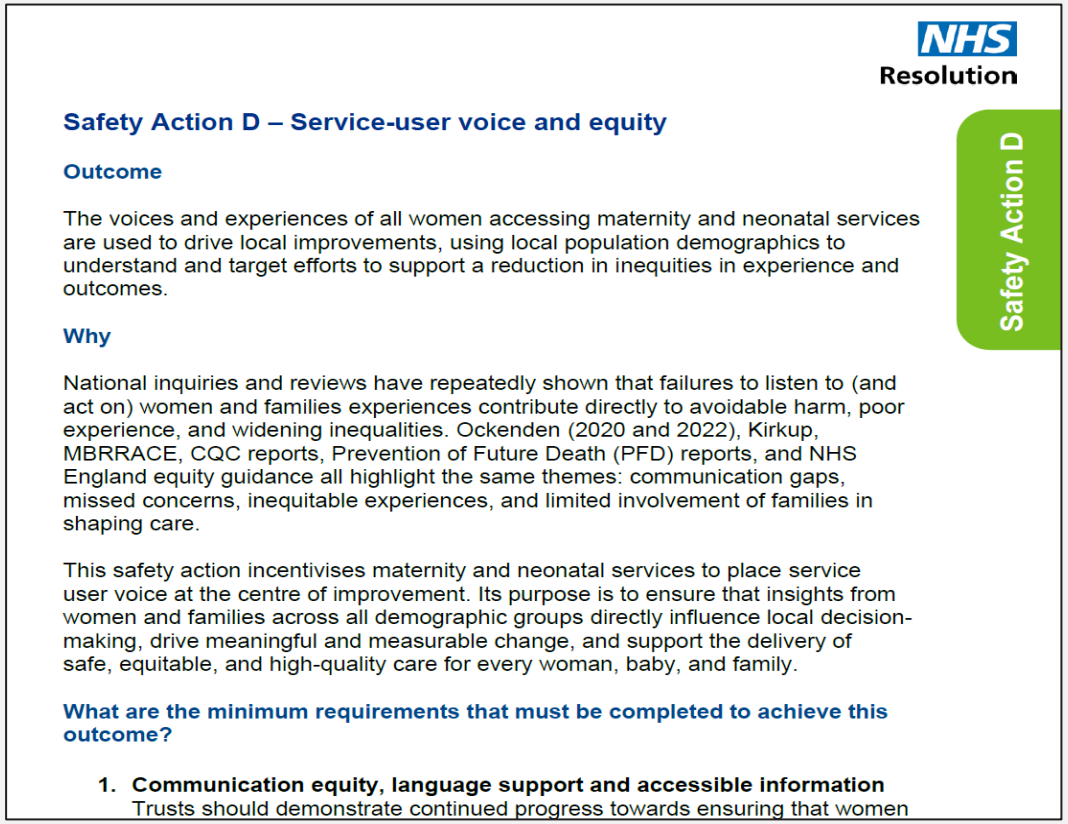
There is a current expectation that service user voice is embedded at all levels of maternity and neonatal care

The t**hree-year delivery plan for maternity and neonatal services recommended ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful** and put service user voices at the heart of service improvement.

How Maternity and Neonatal Voices Partnerships (MNVPs) concerns are escalated:

- Individual service users can feed their thoughts into Maternity and Neonatal Voices Partnerships (MNVPs) at unit level
- MNVPs then feed insights up through the Local Maternity and Neonatal System (LMNS)/ICB (not every LMNS/ICB has a service user voice (SUV) rep at system level) to the regional SUV reps (there is a SUV rep in each of the 7 regions)
- Regional service user voice reps feed insights onwards to National SUV reps (we now have 17 SUV reps for the maternity and neonatal programme which ensures SUV representation on every part of the programme including all committees and at Board).
- This feedback loop goes all the way round, so also from National SUV reps back round to MNVPs.

There is also a **safety action D (SA-D) in the CNST Maternity Incentive Scheme requiring the voices and experiences of all women accessing maternity and neonatal services to be used to drive local improvements**:



NHS Resolution

Safety Action D

Safety Action D – Service-user voice and equity

Outcome

The voices and experiences of all women accessing maternity and neonatal services are used to drive local improvements, using local population demographics to understand and target efforts to support a reduction in inequities in experience and outcomes.

Why

National inquiries and reviews have repeatedly shown that failures to listen to (and act on) women and families experiences contribute directly to avoidable harm, poor experience, and widening inequalities. Ockenden (2020 and 2022), Kirkup, MBRRACE, CQC reports, Prevention of Future Death (PFD) reports, and NHS England equity guidance all highlight the same themes: communication gaps, missed concerns, inequitable experiences, and limited involvement of families in shaping care.

This safety action incentivises maternity and neonatal services to place service user voice at the centre of improvement. Its purpose is to ensure that insights from women and families across all demographic groups directly influence local decision-making, drive meaningful and measurable change, and support the delivery of safe, equitable, and high-quality care for every woman, baby, and family.

What are the minimum requirements that must be completed to achieve this outcome?

1. **Communication equity, language support and accessible information**
   Trusts should demonstrate continued progress towards ensuring that women

Women's experience

What have we done?

- Published **MNVP Guidance**
- **Perinatal culture and leadership programme :** offered to all maternity and neonatal leadership teams. This included a diagnosis of local culture and practical support to nurture culture and leadership.
- Ensured **7day bereavement services** are available in every Trust
- Established **maternal mental health services** in every ICB

Work in Progress

- **Perinatal Equity and Anti-Discrimination Programme** : This will give perinatal teams the skills and tools they need to improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and to improve the working lives of staff from these groups.
- Maternity and Neonatal **PREM (Patient Reported Experience Measure**): A validated national tool providing near real-time feedback on user experience. It will enable Trusts and ICBs to act swiftly on feedback and support national learning on what works
- National **Bereavement Care Pathway**: Sands led the development of the National Bereavement Care Pathway and the nine NBCP bereavement care standards. The NHS has committed to implementing the NBCP standards in all NHS Trusts across England.

4. Additional Action to Support Improvement

Govt action on deprivation and social complexity

Wider action required

- **Obesity**: A BMI of 30+ increases the risk of diabetes, hypertension, thrombosis, stillbirth and neural tube defects as well as increasing the difficulty of accurately providing scans and foetal monitoring
- **Economic deprivation**: Women living in the most deprived areas are more likely to have pre-existing diabetes and hypertension and to experience perinatal mental health conditions
- **Racism**: The impact of racism and discrimination within maternity services is relatively well researched however, this is unlikely to be confined to one service and requires at least a Trust wide approach
- **Pre-conceptual care:** Further action is needed around anaemia, vitamin/mineral deficiencies and pregnancy spacing
- **social determinants of health:** of the women who died, 22% suffered domestic abuse, 21% were known to social services and 14% had multiple disadvantages; maternal age, nutritional deficiencies and air pollution also contribute to mortality and morbidity.

- Smoking in pregnancy is the single biggest modifiable risk factor for poor birth outcomes, increasing the risks of stillbirth, miscarriage, preterm birth, low birthweight, heart defects and sudden infant death
- The achievement of the national target to reduce smoking in pregnancy rates to =<6% shows that wide ranging cross governmental action can be successful

Percentage of women who smoked at time of delivery, England