Maternity care

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 recent national maternity programme – an inspection of all hospital maternity locations that had not been inspected since before March 2021 – showed many of the issues raised are widespread across England.

We are concerned that too many women are still not receiving the high-quality maternity care they deserve. Of the 131 locations we inspected, almost half (47%) were rated as either requires improvement (36%) or inadequate (12%). 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.

These findings highlight that 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 3-year delivery plan for maternity.

The inspection programme identified unsuitable maternity estates as a key issue affecting the quality of care women received. We found several maternity units were not fit for purpose, lacking space, facilities, and in a small number of cases, appropriate levels of potentially life-saving equipment. Our national maternity report called for additional capital investment to ensure women receive safe, timely care in an environment that meets their needs.

Chronic issues around recruitment and retention of the maternity workforce were another barrier to high-quality care. While some services had good oversight of staffing levels, managers did not always have the resources to adjust staffing levels according to the needs of women.

It is vital that maternity services can recruit to maintain safe staffing levels. 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 workload pressures, it is important that leaders 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.

Inequalities in maternity care

In our Safety, equity and engagement in maternity services report and our last State of Care report, we highlighted that there are still unwarranted variations in clinical outcomes for women with protected characteristics under the Equality Act 2010. The most recent MBRRACE-UK data 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.

Our national maternity inspection programme found huge differences in the way trusts collect and use demographic data, particularly ethnicity data, to address health inequalities in their local populations. Without national guidelines, we are concerned that trusts have no way of effectively evaluating if initiatives to make maternity care more equitable are driving much-needed change.

We also found that communication with women and their families is not always good enough, particularly for women whose first language is not English. 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.

Safety of maternity services

The safety of maternity services remains a key concern. When inspecting the safe key question in our national maternity inspection programme, almost half of services were rated as requires improvement (47%), while 35% were rated as good and 18% were rated as inadequate. No services inspected as part of our programme were rated as outstanding for being safe. We found significant variation in the way trusts operated in key areas such as triage and learning from patient safety events.

More work is needed to improve the way services report, learn and communicate with women when things go wrong. Although most services managed patient safety events well, we are concerned that a lack of reporting is leading to harm becoming normalised and opportunities for learning are being missed. While recognised complications such as postpartum haemorrhages may be common to staff and do not always constitute a patient safety incident, 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. Research shows that 4 to 5% of women develop post-traumatic stress disorder (PTSD) after giving birth.

Despite this, we found a significant number of patient safety events went unreported – either because staff were overstretched or because they did not trigger a patient safety incident and were not recorded locally. Not reporting patient safety events such as postpartum haemorrhages suggests a tendency to accept them as inevitable, but we know this is not the case. For example, monitoring levels of haemoglobin after birth can reduce the likelihood of a postpartum haemorrhage. Issues with recording and grading patient safety events could also result in a lack of oversight and missed opportunities to learn from them.

With no national targets or standards for maternity triage, we 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. Maternity triage is a recognised high-risk clinical area, where women who have an emergency or concern about their pregnancy can contact a hospital for an urgent assessment. Staff will use this assessment to prioritise their care.

The first step is usually to call a telephone triage line. Although most services offered a telephone triage service, we saw variation in how effectively they were operated. We found instances where the triage phone went unanswered, which risked missing urgent calls or vital early warning signs. Similarly, 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.

These issues meant that unsafe practice in triage formed the bases of 81% of enforcement actions issued to providers. It was also recognised as a safety concern in around a third of all inspections.