NHS Providers

IMPROVEMENT RACE EQUALITY HEALTH INEQUALITIES

# Supporting boards to address quality and inequality in maternity services

Our mission at NHS Providers is to enable high-quality care for patients and a reduction in health inequalities, by supporting you to work collaboratively within and across local health and care systems.

As part of our member support offer, our **Health Inequalities**, **Race Equality**, and **Improvement** programmes are delivering a series of events on improving maternity and neonatal care outcomes, with a focus on addressing health inequalities. The events will support board members to:

- Reflect on workforce culture and leadership in maternal services.
- Identify and overcome barriers to improving maternal care and outcomes equitably.
- Network and hear examples of good practice.
- Discuss collaborative and system wide approaches to improving maternal outcomes for groups most at risk of inequalities.

In this briefing, we have provided an overview of the current inequalities in maternal outcomes, outlined the role trusts can play in improving maternity services, and provided links to further reading and information.

For more information, please contact: events@nhsproviders.org

## Background and context

The Ockenden review (2022) provided a series of immediate and essential actions to improve care and maternity services across England. Despite a 20% decrease in stillbirth and neonatal deaths in England between 2010 and 2021, other indicators of quality have declined in recent years. Alongside decline in quality, maternity care is marked by stark race and health inequalities. Pregnant women and

people from black and Asian ethnic minority groups are more likely to experience adverse outcomes and additional risks compared to their white counterparts. Findings from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) highlight these racial inequalities, and how deprivation can further exacerbate poor outcomes:

- Women from black ethnic minority backgrounds are four times more likely to die from pregnancy compared to white women.
- Women from Asian ethnic minority backgrounds are twice as likely to die from pregnancy compared to white women.
- Women living in the most deprived areas are 2.5 times more likely to die than women living in the least deprived areas.
- 12% of women who died during or up to a year after pregnancy had multiple severe disadvantages.

Numerous reports from maternity organisations (such as Birthrights, 2020; The Royal College of Midwives, 2021; Sands & Tommy's, 2023), national bodies (such as NHS England, 2019; NHS England, 2023), and regulatory bodies (such as CQC, 2020; CQC, 2022; CQC, 2023) have identified key areas for enhancing the safety, equity and efficacy of maternity services:

- **Workforce culture and leadership:** this includes clear governance and assurance processes from senior leaders; collaborative team working where colleagues feel confident to ask for support and raise concerns; and a culture where inclusivity and accountability is promoted.
- **Patient access and engagement:** this includes implementation of targeted interventions and tailored communication for those at risk (such as actions outlined by the chief midwifery officer in 2020); and utilisation of system and voluntary community and social enterprise (VCSE) organisations to support access and engagement initiatives (such as local Maternity Voices Partnerships).
- **Approaches to quality and improvement:** this includes clear reporting processes and guidelines – where staff feel encouraged to report incidences and use these to facilitate system learning; providing staff with multiple tools and ways to share learning; inclusive multidisciplinary training where the impact of the training was monitored; and triangulation of inequalities data from both patients and staff to review safety outcomes for at risk groups.

Despite these areas being identified and NHS England's pledges to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality, and serious brain injury by 2025, improvement in

maternity services is slow. In 2021, 41% of maternity services were rated as 'inadequate' or 'requires improvement' by the CQC.

# Further reading

## Key reports

- Sands and Tommy's Joint Policy Unit – *Saving babies' lives* (2024)
- Birth Trauma APPG – *Listen to Mums: Ending the postcode lottery on perinatal care* (2024)
- House of Lords Library – *Performance of maternity services in England* (2024)
- House of Commons Library – *Quality and safety of maternity care* (2024)
- House of commons, Women and Equalities Committee – *Black maternal health* (2023)
- Race and Health Observatory – *Review of neonatal assessment and practice in Black, Asian and minority ethnic newborns* (2023)
- Department of Health and Social Care – *Final report of the Ockenden Review* (2022)
- NHS England – *Safe learning environment charter* (2022)
- CQC – *Safety, equity and engagement in maternity services* (2022)
- Birthrights – *Inquiry into racial injustice in maternity care* (2022)
- NHS England – *Ockenden review of maternity services* (2020)
    - Assessment and assurance tool
    - Board measures
    - Core competency framework
- *NHS England – Better births four years on: A review of progress* (2020)
- *Royal College of Midwives – Covid-19 impact on Black, Asian and minority ethnic women (2020)*
- House of Commons, Women and Equalities Committee – *Pregnancy and maternity discrimination* (2017)
- Bill Kirkup – *The report of the Morecambe Bay investigation* (2015)

## Workforce culture and leadership

- NHS England – *Review of midwifery education and training and newly qualified experience: thematic analysis* (2024)
- NHS England – *Maternity support worker competency, education and career development framework* (2024)
- NHS England – *Safe practice principles for adult nurses working as part of multidisciplinary teams in maternity services* (2023)
- Sands and Tommy's Joint Policy Unit – *Better board oversight needed to save babies' lives* (2023)
- CQC – *Getting safer faster: key areas for improvement in maternity services* (2020)

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- The Royal College of Midwives – *Strengthening midwifery leadership: a manifesto for better maternity care* (2019)
- NHS England – *Enabling Black and Minority Ethnic (BME) nurse and midwifery progression into senior leadership positions* (2017)

## Patient access and engagement

- NHS England – *Maternity and neonatal voices partnership guidance* (2023)
- Ipsos & CQC – *Maternity Survey* (2023)
- The Sands – *Listening project report* (2023)
- NHS England – *Communications toolkit for local maternity teams to improve communications with Black, Asian and minority ethnic women* (2021)
- NHS England – *Atlas of shared learning, 'Meet the matrons' clinic* – an initiative to improve patient experiences at Northampton General Hospital NHS Trust (2018)

## Approaches to quality and improvement

- National Institute for Health and Care Research – *Maternity services: research can improve safety and quality of care* (2024)
- National Institute for Health and Care Research – *Maternity services: evidence to support improvement* (2023)
- NHS England – *Maternity self-assessment tool* (2021)
- NHS England – *Equity and equality: guidance for local maternity systems* (2021)
- NHS England – *Supporting mental healthcare in a maternity and neonatal setting: good practice guide and case studies* (2021)
- NHS England – *Personalised care and support planning guidance: guidance for local maternity systems* (2021)
- NHS England – *Improving quality and safety in maternity care: the contribution of midwife-led care* (2019)
- NHS England – *Atlas of shared learning, Improving the quality of care for neonatal patients* – a quality improvement project at Great Ormond Street Hospital NHS Foundation Trust (2019)
- NHS England – *The fifteen steps for maternity: quality from the perspective of people who use maternity services* (2018)