The National Maternity and Neonatal Collective

By us, with us, for us:

Priorities and solutions for the Independent National Maternity and Neonatal Investigation

A co-production from 100 national and grassroots organisations and individuals to rebuild maternity and neonatal care that is safe, equitable, compassionate and human rights-centred for all

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Introduction to the Collective

When the Independent National Maternity and Neonatal Investigation was announced, Make Birth Better considered how many similar inquiries had taken place in recent years. The organisation recognised that the systemic issues contributing to a harmful environment had not improved, but worsened. As the CEO of Make Birth Better, I decided to bring together organisations from across the country, along with individual activists, service users and healthcare professionals, with the aim of identifying areas for improvement and clarifying tangible, achievable solutions. Together, we agreed on the goal of reducing disparities by focusing on the needs of marginalised communities (see Appendix 1), especially Black and brown service users and staff. The Collective's approach aims to disrupt and decolonise the systems causing harm. Getting the system right for marginalised groups will make the service safer and more accessible for all.

Together, over the last eight months, through extensive consultation, collaboration and evidence-gathering, we have co-produced a national Plan of priorities and solutions for the government. This Plan recognises the intersecting layers of inequality, discrimination, oppression and exclusion that shape service users' experiences, and its recommendations clarify what is required to reduce harm.

We hope that the National Investigation will use this Plan to transform NHS maternity and neonatal services, making them safe, equitable, compassionate and rights-based, once and for all.

Laura-Rose Thorogood

CEO, Make Birth Better

Lead of The National Maternity and Neonatal Collective

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Executive Summary

The Landscape

Maternity services in the UK are in a state of deep and urgent crisis. Recurrent investigations identify services in which parents and babies come to avoidable harm, and yet hundreds of subsequent recommendations have failed to bring about any nationwide improvement. People are afraid to access a system known to cause and perpetuate harm, especially to the most marginalised individuals and communities. Black and brown women and birthing people are subject to particularly inequitable outcomes in maternal and neonatal morbidity and mortality, as evidenced consistently by MBRRACE-UK reports.

It must also be acknowledged that maternity staff are at the forefront of this crisis. Midwives' working conditions are people's birthing conditions: one cannot thrive without the other. Surveys by the Nursing and Midwifery Council and the Royal College of Midwives demonstrate persistent levels of burnout, anxiety and distress caused by inadequate staffing, excessive hours and toxic workplace cultures. A lack of psychological and physical safety has contributed to serious problems in midwifery recruitment and retention, making the system even less safe and more pressurised for those who remain.

A Matter of Urgency

Change is needed now. NHS maternity services (See Glossary - Appendix 2) should be a source of national pride; instead, repeated scandals, investigations and enquiries have made it a source of national shame. We cannot continue to pretend that maternity is a niche corner of the health service, deserving of only the most basic funds and resources. The perinatal journey affects each and every one of us; even if we do not all give birth, we are all born. Maternal health is public health. With that in mind, the establishment of a safer maternity service should be a matter of national urgency. This is not about incremental improvement to a failing system. It is about transformation.

Taking Collective Action: Methodology

Co-design and collaboration have been at the heart of this Plan, along with a commitment to centre the needs of Black- and brown-bodied women and birthing people, other marginalised groups and communities, their families and staff. We

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believe fundamentally that when the needs of those most adversely affected by inequity are prioritised, everyone benefits.

To co-produce this Plan, themes and priorities were selected through open discussions and polls, identifying strategies with the greatest potential to create lasting impact and improve outcomes nationally. A smaller working group was formed, bringing together people from diverse communities, experiences, and roles to develop the Plan and present it at monthly meetings with the whole Collective. Over the last eight months, the Plan has been refined to honour the intersectional experiences of service users and staff.

In this document, we will set out priorities for change, along with corresponding solutions from individual to national level, across four interconnected themes:

- Rights, Equity and Anti-Oppression
- Models of Care and Access
- Workforce Retention and Support
- Governance, Accountability and Investment.

All priorities and solutions are rooted in the following principles:

1. Centre maternity care on human rights, bodily autonomy, informed consent, dignity and respect

Maternity services must operate within human rights frameworks, recognising that disrespect, coercion, and lack of informed consent constitute serious harms. All care must uphold the autonomy of women and birthing people to make decisions about their own bodies and care.

2. Prioritise Black, brown and marginalised communities in all maternity policy, design and delivery

Services must be explicitly designed to address the needs and experiences of those at greatest risk of poor outcomes, including Black and brown families, asylum seekers and refugees, disabled and neurodivergent people, LGBTQIA+ families, those experiencing poverty, deprivation or domestic abuse, Gypsy, Roma and Traveller communities, and care-experienced individuals.

3. Formally recognise, prevent and address Obstetric Violence across maternity services

Obstetric Violence—including physical, verbal, and emotional mistreatment, procedures without consent, discrimination, and neglect—must be named,

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documented, monitored, and eliminated. An independent complaints pathway and national framework for accountability are essential.

4. Mandate anti-racist, trauma-informed, human-rights-based training for all maternity and perinatal staff

Initial and ongoing education must be time-protected and embedded in core competencies, covering bodily autonomy, informed consent, safeguarding, obstetric violence, anti-racism, and culturally respectful care. Training must be evaluated annually and extend beyond clinical staff to include governance leads, management, social services, and police.

5. Embed comprehensive perinatal mental health care in every maternity setting

Mental health support must be accessible to all who need it, not just those meeting specialist thresholds. Services should include routine mental health assessments, clear referral pathways, specialist perinatal mental health teams, and dedicated support for bereaved parents and those whose babies are removed at birth.

6. Make continuity of midwifery care the standard model for all service users

All Trusts should have a clear, funded pathway toward full continuity of midwifery care throughout the maternity journey. Those at highest risk of poor outcomes—including Black and brown families, asylum seekers, trans and non-binary people, individuals experiencing socio-economic deprivation and those who have experienced trauma—should be prioritised for Continuity of Carer models, which serve as a protective measure against harm.

7. Protect and expand midwifery-led birth centres and home birth services

Midwifery-led units and home birth provision must be ring-fenced, with safe staffing levels maintained even during periods of service pressure. All birthing options should be equitably accessible, with clear, unbiased information provided to support informed choice.

8. Ensure safe staffing levels, fair pay and humane working conditions for maternity staff

Adequate staffing is a safety imperative. Services require mandatory staff-to-patient ratios; full pay restoration; legally enforceable limits on working hours, with robust auditing systems to ensure adherence to these limits; psychological safety; protected time for reflective practice; and equitable career progression. Black, brown, and marginalised staff must be represented in leadership and research roles.

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9. Design maternity services to be inclusive and accessible by default for all marginalised groups

Services must provide professional interpreting (including sign language), accessible formats (easy read, large print, braille), culturally responsive care, and reasonable adjustments. Physical, sensory, cognitive, and logistical barriers must be identified and removed.

10. Provide ring-fenced, sustained and equitably distributed funding for maternity and perinatal services

Investment must be sufficient, protected, and distributed based on need rather than historical allocation patterns. Funding should support workforce expansion, continuity models, mental health services, estates improvement, and community-based care.

11. Strengthen transparency, accountability and independent complaints mechanisms in maternity care

Trust Boards, CEOs, and regulatory bodies must be held to measurable outcomes on equity, safety, safeguarding, consent, and service user experience, with public reporting and real consequences for non-compliance. An independent complaints pathway for obstetric violence is essential, alongside a strengthened duty of candour.

12. Treat safe, equitable, rights-based maternity care as a public health priority

Maternity care must be recognised as central to population health, requiring cross-government action on the social determinants of health, including poverty, housing, migration policy, and access to healthcare. Political commitment is required to end ethnic disparities in maternal and neonatal deaths.

What Comes Next

Embedding these principles in service design and practice demands political will, sustained investment, cultural transformation and accountability at every level. Now is the time to recognise that current maternity outcomes are the result of foreseeable and preventable systemic failures, not isolated incidents. Successful transformation must prioritise the needs of the most marginalised, challenge medical paternalism, flatten hierarchical cultures and eliminate defensive organisational practices.

We look forward to working with the government, local health boards and other stakeholders to achieve positive change. Together, we can create a safe, equitable, compassionate, rights-centred service of which the country can be rightfully proud.

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Priorities and Solutions

Rights, Equity and Anti-oppression

Priorities

- Enable access to safe, respectful, human rights-centred and personalised maternity care for all.
- Prioritise the needs of Black, brown and marginalised communities, recognising the unique impact of intersecting forms of oppression and marginalisation.
- Prioritise the decolonisation of maternity care.
- Using an antiracist approach, challenge hierarchical structures in maternity services which currently silence service user voices and perpetuate inequities
- Recognise and eliminate all forms of obstetric violence (see Glossary - Appendix 2). Introduce a consistent reporting mechanism and debiasing framework.
- Train the maternity workforce in a human rights-based, trauma-informed and antiracist care framework to help staff understand the interactions of power, control and autonomy.
- Recognise the rights of staff and commit to an equitable workplace free of oppression.
- Challenge medical paternalism and medical misogyny within maternity services.
    - Develop a new framework whose principles respect the rights of service users to make decisions about their own care and respect the voices of all bands of staff.
- Develop more robust ways of identifying domestic abuse in the perinatal period and facilitating appropriate support for service users who are at risk.
- Develop consistent minimum standards of national guidance that provide accessible information and translation services to enable the most vulnerable of families to navigate the maternity system safely and confidently.

Solutions

- Establish anti-racism and debiasing frameworks in maternity and perinatal services, with accountability for institutional harm.
- Identify in advance any need for, and provide high-quality interpreting services (taking dialects into account), including sign language and braille, as standard for those who need it, along with translations of written materials.

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    - Establish ongoing training and education for all staff around working with face-to-face, virtual and telephone interpreters.
- Provide accessible materials, e.g. easy read, large print, braille, in all places that standardised written materials are placed.
    - Ensure service users are aware that reasonable adjustments can be made based on need.
- Mandate a programme of initial and ongoing (in Core Competencies framework) time protected education and training for all relevant staff (including governance leads, frontline maternity staff, management at the provider level, social services staff and the police) to understand and respect the autonomy of maternity service users in making decisions about their maternity care, both to prevent human rights breaches and obstetric violence and to ensure good support for victims. This must include:
    - Bodily autonomy, human rights and equality law, enabling informed decision making and ensuring informed consent
    - Safeguarding
    - Obstetric violence
    - Anti-racism
    - Religious and culturally respectful practices (see list of marginalised communities, Appendix 1)
    - Provision of care which is inclusive for marginalised communities (see Appendix 1)
- Establish ring-fenced, sustained and equitable funding for maternity and perinatal services.
- Develop a new mechanism offering an independent pathway for all maternity complaints, staffed by those with the specialist training to understand the issue of obstetric violence, ensuring that lessons learnt are shared nationally
    - A new national framework for monitoring and dealing with incidents of obstetric violence, with transparency for the public, including an annual review and the timely publication of data around complaints of obstetric violence by maternity service providers.
- Provide independent information to all maternity service users explaining the concept of obstetric violence, their rights, and the complaints pathways available.
    - Such information should also be made available to fathers, non-birthing parents, other supporters and family members (see Glossary - Appendix 2).
- Create national minimum standards of services which are inclusive by design, ensuring accessibility for disabled and/or neurodivergent people, and addressing all aspects of access — physical, sensory, cognitive, and logistical. They should also be equipped to make reasonable adjustments to

meet individuals' specific needs.

- Conduct a formal review of MNVP structure and funding (with full substantive contracts and employment rights), employed outside of Trust, to ensure equity and equality and representation of a diverse range of service user voice. Ensure the needs of Black and brown women and birthing people and those from marginalised communities (see Appendix 1) is centred in service design, policy, and research to ensure feedback improves localised outcomes.
- Bring all policies and guidelines into compliance with the human rights framework and embed autonomy, anti-racism and cultural safety as explicit principles.
- Review and improve availability and accessibility of up to date, evidenced based resources for all, ensuring co-production with those from marginalised communities (see Appendix 1).
- Conduct an extensive review of education, examinations, training and clinical guidance to decolonise the curriculum and ensure not only white bodies are centred, and that variations within specific ethnic groups are understood and addressed, without pathologising.
- Develop and share learnings from locations with positive feedback i.e., where all service users state that their rights, beliefs and values have been respected
- Standardise assessment and documentation of social risk factors at booking appointments and at least once more later in pregnancy.
    - Ensure that codes for flagging domestic abuse are applied in women and birthing people's records and are known to all those caring for them.

Models of care and access

Priorities

- All care to be trauma-informed.
- Perinatal mental health support should be comprehensive and embedded in every maternity setting.
    - All services, including primary care, should be responsible for perinatal mental health, including prevention, identification, early intervention, and treatment as appropriate.
    - There should be clear, standardised criteria for, referral and signposting routes into maternal mental health services and specialist perinatal mental health care (including community provision, bereavement support and inpatient Mother and Baby Units). This should include the postpartum period and subsequent pregnancies. Offers of signposting

to support for siblings and extended family members should also be considered.
    - Increased specialist support is needed for bereaved parents and those facing the removal of their babies at birth.
    - Women and birthing people whose babies die or are removed at birth should not be automatically discharged from specialist perinatal mental health teams, and should be supported to access an appropriate specialist service.
    - Support should be available for the large number of women and birthing people - over 90,000 annually - who experience mental health or emotional wellbeing needs but do not meet the threshold for specialist perinatal mental health services.
- All Trusts should have a clear pathway towards full Continuity of Carer for all as the standard model throughout the maternity journey. This needs to be appropriately funded, staffed and implemented, including training and reorganisation, with adequate support for staff during transitions to, and while working in shift patterns that may differ significantly from their previous roles.
    - Those most at risk of poor outcomes should be case loaded first - Black and brown families, asylum seeking/refugee families, trans and non binary people, and those who have experienced perinatal loss and birth and perinatal trauma (hereinafter referred to as perinatal trauma - see Glossary, Appendix 2) and other forms of trauma, abuse, and adversity including people who are care experienced (see Glossary, Appendix 2) and people who have experienced domestic abuse. Continuity of Carer is a protective measure for the wellbeing of vulnerable marginalised groups and it is especially important when a birthing person has multiple marginalised identities (see Appendix 1).
    - Pending the development of full pathway Continuity of Carer, services should ensure that all services users see the same midwife/obstetrician for antenatal and postnatal care.
    - Develop and mandate a standardised onboarding framework for women and birthing people who transition between maternity providers, including those from Gypsy, Roma and Traveller communities, military families, asylum seekers and refugees, and individuals who are homeless or at risk of homelessness. The framework should further encompass people experiencing domestic or forced displacement and others whose housing, immigration, occupational or safeguarding circumstances result in high mobility or disrupted engagement with services. It should facilitate advance contact or self-referral, ensure the timely and interoperable transfer of clinical information, embed culturally competent and trauma-informed practice, address practical

barriers to access, and enable the prompt re-establishment of Continuity of Carer models while minimising the need for individuals to re-disclose traumatic histories.
    - Equitable and accessible provision of information about grassroots organisations, peer support, counselling and third sector organisations providing support for families affected by perinatal loss
- Equity of access and clear information made available about all birth options - home birth, midwife-led units, obstetric units and bereavement and neonatal care.
    - Promotion and protection of midwifery-led birth centres - stop closures, expand provision, ensure safe staffing levels.
    - Ring-fenced, high quality dedicated provision for homebirths avoiding suspensions or restrictions at short notice.
- Build relationships, provide clear information, listen, answer questions, revisit decisions, and support parents who change their minds, or who make informed decisions that are not in line with standard or routine care provision.
- Comprehensive, evidence-based diagnostic protocols that detect serious pathology before it becomes an emergency, particularly for asymptomatic conditions in high-risk groups
- Equitable access to high quality antenatal education tailored to individual needs - in terms of content, learning methods and format offered.
    - National minimum standards for key content and a framework for delivery.
- Substantial investment in community-based women's health hubs, to provide equitable access to care across the life course in sexual and reproductive health and rights, including delivering community maternity care outside of the hospital where appropriate.
- Maternity services to be designed and provided with an understanding of physiology in order to both maximise the chances of pregnancy, labour, birth and the postnatal period remaining problem-free and support the delivery of timely, safe and effective medical treatment when this is beneficial and wanted.
- Ensure that fathers, non-birthing parents, other supporters' roles are respected, validated and acknowledged and appreciate that they too can experience trauma.

Solutions

- Restore ring-fenced, sustained and equitable funding to enable recommended improvements to maternity and perinatal services including perinatal mental health services.

- Mandate a routine offer for mental health assessments where every woman and pregnant person could receive a structured, compassionate mental health assessment during antenatal care, and post natal care (including the 6-8 week GP check up), using validated tools and delivered through trauma-informed care and conversations rather than tick-box exercises
- Create national standards for trauma-informed care.
- Encourage and empower staff in discussing with senior colleagues where required for further investigation of any potential health conditions requiring specialist input, including life threatening conditions with integrated intervention pathways. Ensure systematic and comprehensive assessment of risk factors for poor outcomes or death. Offer psychological support for all teams with peer support and pathway provisions to ensure those below specialist thresholds are included. Ongoing and mandatory training for mental health recognition and triage for those working in perinatal services.
- Mandate regular trauma-informed education and training for all staff in maternity and perinatal care on:
    - How to provide trauma-informed care;
    - Perinatal trauma, bereavement and loss;
    - Informed decision-making and the law on consent.
    - Support needs of fathers, non-birthing parents and other supporters.
- Effective implementation of national perinatal trauma pathway with service user input and ensure this is implemented nationally
- Review current bereavement care pathway and ensure this is implemented nationally. To be available for all gestation and losses, and those who have children removed or at risk of removal.
- Provide staff with lists of approved national and local services to which they can signpost women and parents such as safeguarding, domestic abuse support, perinatal mental health care, or housing and financial support, parent groups, cafes that support breast/chestfeeding, children's play groups etc.
- Design all care models, policies and guidelines to centre human rights, be equitable, accessible, and capable of delivering personalised care. These should be underpinned by the legal framework including The Human Rights Act 1998, The Equality Act 2010, key consent caselaw and the Professional Codes of Conduct for Health and Care Professionals, and be robustly assessed against an accredited equity measuring tool during both design and review/audit.
- Ensure adequate funding, availability, and accessibility of resources, e.g. easy read materials and braille.

Workforce Retention and Support

Priorities

- Ensure suitable staffing at all levels across all maternity and perinatal services and ring-fence staff for vulnerable services such as Continuity of Carer, birth centres and homebirth provision to guarantee equitable and safe provision for choice of birth across the NHS, rooted in the needs of women and birthing people.
- Establish systems of audit and accountability to ensure that staff's human rights are being met.
- Embed an awareness of human factors in all aspects of service provision and design.
- Improve working culture, morale and conditions to address retention of all staff, in particular midwives.
    - Acknowledge and address surge in racism towards staff and service users in the NHS
    - Develop a culture that is conducive to psychological safety and physical wellbeing enabling staff to provide the level of care that is imperative for patient safety.
    - Safer staffing numbers and shift patterns.
    - Establish equitable pay leading to full pay restoration
    - Ensure working conditions currently adhere to legislated workplace protections and support staff's human rights.
    - Ensure equitable and inclusive hiring practices
    - Access to mandated psychologically safe reflective practise and support
    - Fair career progression pathways and opportunities
- Ensure greater representation of marginalised staff (including, Black, brown, disabled, neurodivergent, and LGBTQIA+ staff) in management and research roles.
- Put in place system-wide solutions to address vicarious trauma and burnout amongst staff.

Solutions

- Ring-fence, sustainable and equitable funding for maternity, neonatal and perinatal services.
    - develop a national taskforce to facilitate greater representation of marginalised staff in management and research roles', with ringfenced funding to implement recommendations

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- Review staffing levels and the accuracy of Birthrate Plus.
    - Fund independent research or simulation using real world data to understand how well the Birthrate Plus model performs in the current context of midwifery practice and identify any necessary improvements.
    - Set mandatory national staff-patient ratios, including babies in patient numbers, for antenatal, intrapartum and postnatal, neonatal inpatient care. Establish an audit system to determine whether these ratios are being adhered to, and develop an accountability structure to ensure staffing ratio issues are addressed where needed.
    - Ensure maternity services have an appropriate skill mix of junior and senior staff across all clinical areas for all hours the service is running.
    - Establish a statutory, legally enforceable, UK-wide cap on midwives' working hours that goes beyond the current Working Time Regulations, mitigating the role that exhaustion and other human factors play in the current maternity crisis. Establish a robust system of audit and accountability to ensure that trusts adhere to this framework, with any 'opt out' based on strictly defined emergency circumstances, time-limited and subject to compulsory review.
    - Establish a national preceptorship programme to support newly qualified midwives and aid retention, setting key proficiencies and ringfencing time for NQMs to complete these. Also ringfence time for senior midwives to support their preceptees.
- Ensure managers have regular, mandatory, ringfenced training that will allow them to identify and mitigate human factors such as fatigue and burnout.
- Correct any longstanding real-terms pay cuts and pay increases equal to or above the rate of inflation thereafter for maternity staff.
    - Improve affordability of midwifery training as outlined by the Royal College of Midwives (abolition of tuition fees in England, maintenance loans for student midwives that would be forgiven after three years of service in the NHS, financial support that increases by inflation, preservation of benefit entitlements, prompt reimbursement of student placement costs).
- Streamline and standardise national accessible record keeping processes, ensuring safety of patient information and allowing all staff to do the job they want to do, spending more of their time with women and birthing people than with records/organisation.
- Improve working conditions for maternity staff by fostering a positive workplace culture, ensuring adequate rest and flexibility, and embedding wellbeing as a core element of safe, high-quality maternity care.
- Require midwives in managerial positions to complete a mandatory minimum number of hours (including night shifts/late shifts) of clinical work per year, in

order to gain a complete understanding of the particular challenges of their area, and to better support staff in meeting those challenges.
    - Improve career development pathways for mid-career and senior midwives, including ringfenced time and funding for CPD activities, establishment of Advanced Midwifery Practitioner roles across the service, and Consultant Midwife post(s) in each trust.
    - Ensure that midwifery and obstetric staff in leadership or managerial positions receive formal training including in psychological safety, accountability & duty of candour, responding to complaints and reviewing outcomes data and serious incidents.
- Empower midwifery educators to develop curricula which recognise the key aspects and benefits of midwifery care, while also meeting the needs of today's NHS midwifery workforce.
    - Midwives must be comprehensively educated and have practical experience of physiological pregnancy, labour, birth, and postnatal adjustment, and be enabled through training, staffing levels, models of care - to protect and support physiological processes in any birth.
- Recognising their sustained exposure to trauma, high emotional labour, and moral injury, maternity staff should have access to regular, proactive wellbeing support through robust, statutory systems, alongside responsive support when difficulties arise. This should include:
    - Protected, psychologically informed clinical supervision embedded within working hours and available routinely, not only in response to adverse events.
    - Regular facilitated reflective practice to support emotional processing, learning, and workforce sustainability.
    - Timely access to confidential counselling and specialist psychological support, including in response to vicarious trauma and burnout.
    - Clear guidance for accessing further support.
- Ensure safeguarding for staff to carry out their roles without fear of discrimination
    - Training for management and all staff in recognising, and taking appropriate action to resolve incidents of racial discrimination or abuse.
    - Acknowledge and support trauma caused to staff being racially abused by patients and colleagues by establishing a safe pathway to escalate and resolve incidents and ensure that appropriate support is provided for their wellbeing.
    - Ensure accountability for addressing incidents of discrimination or abuse as well as formal review of workplace culture leading to an action plan to address any issues identified.
    - The ability to safely whistleblow anonymously without fear of

repercussions where they witness discrimination or any circumstance that may endanger patient or staff safety, as enshrined in the NMC's 'duty of candour'.

- Strategic pathway for support and training of international staff (midwives and nurses) and support for their wellbeing and financial viability to continue their roles.
- Set specific and reasonable targets that are equitable and prioritise staff and patient safety to achieve increased representation of Black and brown staff, especially within senior leadership and research roles.
    - Develop a national taskforce on this issue which would set clear recommendations and mechanisms for accountability.
    - Cohesion with the Access to Work framework to remove workplace barriers and promote inclusion for those whose needs have not been traditionally centred within the NHS workplace.
    - Ensure appropriate individualised support where necessary, and embed an inclusive culture to enable autistic and neurodivergent people to thrive in the workplace

Governance, Accountability and Investment:

Priorities

- Government commitment to maternity as a key priority with **sustained investment** and SMART accountability for implementation of improvements in relation to all areas of service delivery.
    - Accountability and public transparency at regional and local levels through minimum annual audit and public reporting from each Trust. Use financial incentives to ensure compliance.
    - Improvements to maternity services requires a change management process with allocation of sufficient funding in every trust to implement major cultural changes.
    - Ensure that regulatory bodies, such as Care Quality Commission (CQC) and Nursing and Midwifery Council (NMC), are contributing to transparency and accountability with clear internal decision making processes. These bodies should be regularly reviewed and held accountable by the Government.
- Recognise maternity estates as a patient safety and equity issue, not an infrastructure afterthought. Poorly designed, overcrowded, or degraded environments directly contribute to perinatal trauma, adverse outcomes, staff burnout, and inequitable care

- Formalise pathways for collaboration and communication between NHS, charities, and community organisations.
    - Fair remuneration, trauma-informed facilitation and rigorous accountability must be built into all co-design involving grassroots and charitable organisations and their individual participants. Ensure this leads to actionable changes which are fed back to the communities involved.
- Ensure that marginalised communities (see Appendix 1) are explicitly considered in national crisis planning and preparedness for maternity and perinatal services. Crisis response frameworks (e.g. for pandemics, industrial action, or system pressures) must embed equity, inclusion, and safeguarding to prevent the disproportionate impacts seen during COVID-19
- Evaluate quality of maternity services through routine detailed qualitative feedback from a representative sample of users to assess their experience against agreed standards.
- Ensure equitable distribution of maternity funding nationally to reduce the geographical lottery of care.
    - Save costs through appropriate allocation of funds to meet the needs of each region.

Solutions

- Transparent accountability structures.
    - Trust Boards, including CEOs, and regulatory bodies to be held to measurable outcomes including equity and equality, access, service user experience, consent and perinatal trauma and implementation of transformation initiatives. These must be visible publicly with real consequences for non-compliance.
- Annual national review of estates to ensure facilities are fit for purpose with ring-fenced funding to bring all units up to standard.
    - Expand the remit of the Care Quality Commission to explicitly assess whether maternity estates enable safe, dignified, equitable care and the impact of estate constraints on clinical risk and service user experience.
- Political commitment to the NHS becoming an anti-racist organisation.
- Political commitment and target to end the ethnicity gap in maternal and neonatal deaths.
- Political commitment to research-informed policy making, and to modelling of unintended consequences before introducing any new recommendations for practice
- Set specific targets and use positive action to achieve increased

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representation of those from marginalised groups within all tiers of staff, Trust Governance Boards, regulatory bodies, guideline groups, advisory committees and lay-examiners.

- Political commitment to recognise the unique role of midwives in promoting maternal, neonatal and public health, commitment to recognise the challenges of enacting the midwifery philosophy of care in contemporary maternity systems within the NHS, and commitment to include the voices of currently practicing midwives from a broad spectrum of geographical and clinical areas in this and any future review.
    - Understand that better outcomes are linked to those areas and countries with more emphasis on midwifery care
    - Political commitment to recognise the delivery of safe, equitable, rights-based perinatal care as a vital public health intervention rather than a niche part of healthcare provision.
- Evaluation and accountability for all policies, ensure data on outcomes

Evidence and Referencing

This report draws on a wide range of academic and policy sources, detailed in an annotated bibliography and found in the annex of this report (**Appendix 3**). These sources inform and contextualise the issues identified and the solutions proposed. They are used alongside, rather than above, lived experience, community knowledge, and professional and practitioner insight.

An annotated bibliography has been adopted instead of mapped, point-by-point references to avoid false precision and the implication that complex, systemic harms can be reduced to discrete citations. Many of the issues addressed in this report, including racism, coercion, unsafe organisational cultures, and trauma, are relational, cumulative, and historically under measured.

The bibliography situates the Collective's analysis within established academic, legal, policy, regulatory and ethical frameworks, demonstrating that the concerns raised are well documented and widely recognised. This approach reflects a deliberate commitment to evidence that supports accountability and learning, while affirming that lived and learned experience remains central to how the report understands harm and shapes its analysis and recommendations.

Appendices

1. Systems of marginalisation and intersectional identities

We list below systems of marginalisation drawn from well-established academic and global public health frameworks that describe how structural power shapes inequality, including Intersectionality theory (Crenshaw, 1989; 1991), the Reproductive Justice framework (Ross & Solinger, 2017), and the World Health Organization's Social Determinants of Health (WHO, 2008). These frameworks demonstrate how racism, misogyny, classism, ableism, xenophobia, heteronormativity, and other structural forces interact to shape disparities in maternity and perinatal outcomes. Contemporary evidence on maternity inequity further illustrates how these systems impact access, quality of care, safety, and lived experience (Bailey et al., 2017; Vedam et al., 2019; Roberts, 1997/2022).

Individuals may: experience marginalisation through multiple systems simultaneously, recognise themselves within systems not explicitly listed, and move in and out of certain systems depending on context, health status, or life stage.

The list is non-exhaustive and does not attempt to capture every lived experience or identity. The purpose of this list is not to define or limit people's experiences, but to highlight the structural forces that shape inequity in maternity and perinatal care, so that services can centre those who have been systemically de-centred, and respond with equity, compassion, and human rights-based practice.

The following examples illustrate some of the communities and groups whose experiences and needs must be centred. Many people belong to more than one group, facing intersecting barriers to safe, equitable, and respectful maternity care. Others may recognise themselves within these systems of marginalisation even if they are not explicitly listed; the focus is on addressing the structural inequalities that shape these experiences

Racism and ethno-religious discrimination:

Black and brown women and birthing people; women and birthing people of Jewish, Muslim, Hindu, Sikh, Buddhist and other faiths.

Migration and immigration:

Migrant women and birthing people, refugees, asylum seekers, and people with insecure or undocumented immigration status, including those affected by NHS charging regulations.

Linguistic, cultural and religious exclusion

Women and birthing people who do not speak English as a first language, and those facing inequalities based on their cultural or religious background.

Sexual orientation, gender identity and family structure:

LGBTQIA+ people and families, including same-sex parents, trans and non-binary birthing people and other LGBTQIA+ family formations and roles within them.

Ableism and disability-based exclusion; neurodivergence-related marginalisation; mental health and trauma related marginalisation:

Deaf and disabled people; neurodivergent people; those with chronic illness, learning disabilities, mental health conditions; new and expectant parents of children with disabilities and or temporary perinatal conditions or co-morbidities.

Sizeism and weight-related stigma:

Larger bodied women and birthing people and those with higher BMIs

Socio-economic inequality and insecurity and class-based marginalisation:

People experiencing poverty, homelessness or housing insecurity; sex workers; people affected by domestic abuse, sexual violence, trafficking or exploitation.

Inequalities, marginalisation and challenges associated with multiple births

Multiple birth families and pregnancies with twins, triplets or more.

Institutional/Structural marginalisation

Women and birthing people who are care experienced.

Ageism:

Younger and older mothers and birthing people.

Justice and safeguarding context:

Women and birthing people in prison, on probation, or facing social services involvement.

Geographic and spatial inequality:

People living in rural or remote areas; those facing digital exclusion; military families; communities in under-resourced or devolved regions.

2. Glossary of terms

Care experienced
People who are currently, or have previously been, in care at any stage of their life - including time spent in foster care, residential care, kinship care, or being looked after at home with a supervision requirement. It may also include adopted children who were previously looked after by the state

Continuity of Carer
A model of relational midwifery care, in which the whole of the maternity journey is supported by a known midwife who provides all or most of the midwifery care, including during labour and birth, and supports all other interactions with the maternity service. When care is provided by a doctor or other specialist, there should also be continuity of the person providing that care.

Fathers and non-birthing parents and other supporters
Fathers and non-birthing parents, including those in LGBTQIA+ families, and who may or may not be the biological parent.

Maternity services
Includes all NHS maternal health and community-based maternal health services.

Obstetric violence
Any form of disrespectful, discriminatory or abusive treatment carried out by maternity services staff during conception, pregnancy, childbirth or shortly after birth, which violates a person's integrity, rights, dignity and autonomy Obstetric violence can take many forms: emotional, physical, sexual, institutional and coercive, including neglect, verbal or physical violence, confidentiality breaches, poor documentation, discrimination, and medical prescription and procedures being performed under coercion or without informed consent.

Perinatal trauma
A person's **self-identified** experience of interactions and/or events related to pregnancy, birth, or the postnatal period that **caused significant distress** and may result in short- and/or long-term negative impacts on physical, emotional, and psychological wellbeing.

Women and birthing people
This term is used throughout the document to refer to all people who use maternity and reproductive health services, including women, trans men, non-binary people, gender non-conforming people and others who may become pregnant, use fertility services, give birth, or experience perinatal loss.

3. Annotated Bibliography

Methodological note

This bibliography supports the Collective's work by collating key academic, policy, legal, regulatory, and practice-based sources discussed during its meetings. These sources were introduced by members and considered alongside lived, professional, and clinical experience, without assuming a hierarchy between different forms of knowledge. They were then compiled to show how sources and experience were used together to identify priorities and develop recommendations. An annotated bibliography was used in place of map-referencing to reflect how sources were discussed and interpreted, what they made visible at a system level, and to avoid false precision. Annotations indicate how each source contributed to the Collective's understanding of patterns of harm, system conditions, and routes to accountability and reform, including where sources point to practices and system features associated with safer and more equitable care. Language in the annotations generally follows the terminology used in each source; where the Collective speaks in its own voice, it uses the terms adopted across the report.

National maternity safety, system failure, and accountability

Care Quality Commission (CQC) (2024) Maternity services in England: National review 2022–2024. London: CQC.

Annotation:

This national review synthesises regulatory findings from inspections and oversight activity across maternity services in England, identifying recurring risks including staffing shortfalls, inconsistent quality, and governance weaknesses. The recurrence of similar concerns across multiple providers and regions supports an interpretation of harm as shaped by system-level conditions rather than isolated failures. The Collective used this review as regulatory evidence that longstanding safety risks are patterned, foreseeable, and require national accountability and coordinated action.

Department of Health and Social Care (DHSC) (2025) National maternity investigation launched to drive improvements. London: DHSC. Available at: https://www.gov.uk/government/news/national-maternity-investigation-launched-to-drive-improvements (Accessed: 13/01/2026).

Annotation:

This announcement sets out the establishment of a rapid national investigation into maternity and neonatal services in England. It signals that concerns about safety and

quality are being treated as systemic and requiring scrutiny beyond routine performance and improvement mechanisms. Within the Collective's discussions, it was used to evidence escalation to national oversight and to frame recommendations for independent investigation and learning.

Hollnagel, E., Wears, R.L. and Braithwaite, J. (2015) From Safety-I to Safety-II: A white paper. Resilient Health Care Net.

Annotation:

This report, which has subsequently spurred a range of research activities and new thinking in healthcare can be applied to maternity care. Here, the concept of 'Safety II' challenges the previous reductionist approach to learning from healthcare 'failings' towards an approach that accommodates the complexities of healthcare systems. Here, 'Safety II' seeks to understand 'failings' in the wider context of where things go well, for changing the conditions based solely on 'what has gone wrong' may change the conditions of what works well – thus worsening the system, service or care. It is important to consider new approaches to tackling the persistent issues in maternity care.

House of Commons Library (2025) Maternity services in England (CBP-10447). London: House of Commons Library. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-10447/ (Accessed: 13/01/2026).

Annotation:

This briefing draws together parliamentary evidence on staffing pressures, service demand, and safety concerns. Read alongside regulatory and inquiry findings, it makes clear that the challenges described in this report have been visible at national level for a long time and that the current crisis was foreseeable.

Kirkup, B. (2022) Reading the signals: Maternity and neonatal services in East Kent. London: Department of Health and Social Care.

Annotation:

This independent investigation examines maternity and neonatal services in East Kent, documenting repeated missed warning signs, failures to respond to concerns, and weak accountability mechanisms. It illustrates how organisational defensiveness and fragmented oversight can allow unsafe practice to persist despite the availability of information indicating risk. The Collective drew on this report as a case example of how governance and culture failures translate into prolonged harm and to support

calls for independent complaints and learning systems.

Liberati, E. G., Tarrant, C., Willars, J., Draycott, T., Winter, C., Kuberska, K., Paton, A., Marjanovic, S., Leach, B., and Lichten, C. (2021). Seven features of safety in maternity units: a framework based on multisite ethnography and stakeholder consultation. BMJ Quality and Safety, 30(6),444–456.

Annotation:

This research paper describes an extensive study exploring what safety within hospital maternity units looks like, describing seven key components. Again, here the emphasis is learning from what works well, why and how to offer important insights to base improvements upon.

Ockenden, D. (2022) Final report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. London: Department of Health and Social Care.

Annotation:

This inquiry documents extensive avoidable harm and death over many years, alongside repeated failures to listen to women and families and to act on known risks. It demonstrates how information about safety concerns existed but was not effectively translated into action due to cultural, leadership, and governance failings. The report informed the Collective's understanding of how systemic failures, rather than lack of data, underpin some of the most serious maternity harms.

Woodward, S. (2022) 'Maternity in the spotlight: patient safety now', All4Maternity. Available at: https://www.all4maternity.com/maternity-in-the-spotlight-patient-safety-now/ (Accessed: 13/01/2026).

Annotation:

This article, written by one of the leaders within 'Safety II' demonstrates how it applies specifically to maternity care and explores the importance of cultivating a 'just culture', building psychological safety for staff which includes safety to speak up and respectfully challenge. Additionally, Safety II describes the difference between 'work-as-imagined' (policies, guidelines, protocols) and 'work-as-done' which is the adaptation to complex changing conditions e.g., reorganising work because of staff sickness, managing multiple unexpected emergencies etc.

Human rights, consent, equality, and professional accountability

Association for Improvements in the Maternity Services (AIMS) (2021) Position paper: Obstetric violence. London: AIMS. Available at: https://www.aims.org.uk/assets/media/729/aims-position-paper-obstetric-violence.pdf (Accessed: 05/01/2026).

Annotation:

This position paper defines obstetric violence as disrespectful, abusive, or coercive treatment within maternity services and situates it within international human rights frameworks. It draws on service-user accounts to demonstrate how such practices undermine bodily autonomy and can cause long-term physical and psychological harm. The Collective used this paper to inform its definition of obstetric violence and to frame patterns of disrespect and coercion as systemic harms requiring formal accountability and reform.

Birthrights (2022) Systemic racism, not broken bodies. London: Birthrights.

Annotation:

This inquiry brings together testimony and legal analysis to document racism, coercion, and neglect within maternity services. It is particularly important because many of the harms described are absent from routine safety data, yet recur consistently in the experiences of Black and brown women and other marginalised groups.

Coulter, A., Locock, L., Ziebland, S. and Calabrese, J. (2017) 'Montgomery v Lanarkshire Health Board: transforming informed consent in health care', BMJ, 357, j1745. doi:10.1136/bmj.j1745.

Annotation:

This paper examines the practical implications of the Montgomery judgment (listed below) for healthcare practice, particularly the shift toward shared decision-making and patient-centred disclosure of risk. It highlights how deeply embedded professional cultures and organisational routines can obstruct meaningful consent despite legal clarity. The Collective used this analysis to support discussion about consent as a cultural and systemic issue rather than a procedural or individual failing.

Montgomery v Lanarkshire Health Board [2015] UKSC 11.

Annotation:

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This Supreme Court judgment established that patients are entitled to information about material risks and reasonable alternatives, judged from the patient's perspective rather than professional discretion. It sets a legal standard requiring dialogue, respect for autonomy, and

shared decision-making in healthcare. The Collective used Montgomery as an anchor for discussions about consent, accountability, and the unlawfulness of coercive or dismissive maternity practices.

De Backer, K., Rayment-Jones, H., Montgomery, E. and Easter, A. (2025) 'Separation at birth due to safeguarding concerns: using reproductive justice theory to rethink the role of midwives', Birth, 52(3), pp. 412–420. doi:10.1111/birt.12842.

Annotation:

This paper examines mother–baby separation at birth in the context of safeguarding, using reproductive justice theory to interrogate how power, risk, and responsibility are constructed within maternity services. It highlights how decisions framed as safeguarding interventions can undermine autonomy, disproportionately affect marginalised women, and reproduce harm when social context, structural inequality, and lived experience are insufficiently considered. The paper informed the Collective's thinking about the human rights implications of safeguarding practices in maternity care, particularly the need for accountability, transparency, and proportionality in decision-making. It contributed to discussion about the ethical and professional responsibilities of midwives and other practitioners to uphold dignity, autonomy, and relational care, even within highly regulated and risk-focused systems.

Del Real Fernandez, S., Law, S. and Feeley, C. (2025) 'Systematic unkindness, systematic invisibility: obstetric violence in the United Kingdom', [Journal publication details forthcoming].

Annotation:

This study is the UK arm of the international 'Birth Experience Study' which has collated 2339 completed surveys of women and birthing people's contemporary childbirth experience in England, Wales, Scotland and Northern Ireland. The survey asked whether the participants had experienced Obstetric Violence (OV) and 17% reported OV. There were a number of factors that influenced whether participants reported OV including personal characteristics (e.g., those not born in the UK were more likely to report OV), interpersonal characteristics (e.g., those who wrote a birth plan but were not supported by maternity professionals were more likely to report

OV) and system characteristics (e.g., those less satisfied with continuity of care or had less familiarity with their caregivers were more likely to report OV).

Fair, F.J., Furness, A., Higginbottom, G., Oddie, S.J. and Soltani, H. (2025) 'Systematic review of Apgar scores and cyanosis in Black, Asian, and ethnic minority infants', Pediatric Research, 97(3), pp. 939–952. doi:10.1038/s41390-024-03149-6.

Annotation:

This systematic review synthesises evidence showing that Apgar scoring and visual assessment of cyanosis are less reliable in infants with darker skin tones. It demonstrates how assessment tools developed and validated primarily in white populations may increase the risk of delayed recognition of clinical compromise in infants from ethnic minority families. The Collective used this evidence to illustrate how apparently neutral clinical standards can embed structural bias and create unequal safety outcomes.

Fair, F., Furness, A., Higginbottom, G., Oddie, S., and Soltani, H. (2023). Review of neonatal assessment and practice in Black, Asian, and minority ethnic newborns. Exploring the Apgar score, the detection of cyanosis, and jaundice. NHS Race & Health Observatory. (Accessed: 05/01/2026).

Annotation:

This review brings together clinical, policy, and practice-based evidence to examine how neonatal assessment methods, including Apgar scoring and the detection of cyanosis and jaundice, perform for Black, Asian, and ethnic minority newborns. It highlights gaps in guidance, training, and clinical confidence when assessing babies with darker skin tones and identifies risks arising from reliance on visual indicators that have not been validated across diverse populations. The review contributed to the Collective's discussions about professional accountability and equality, making visible how systemic omissions in standards and education can translate into unequal safety at the very start of life. Read alongside subsequent academic reviews, it reinforces the need for deliberate, equity-informed reform of neonatal assessment practices rather than reliance on inherited norms that may disadvantage some groups.

Feeley, C. (2023). Skilled Heartfelt Midwifery Practice: Safe, Relational Care for Alternative Physiological Births. Springer International Publishing.

Annotation:

This book (published after extensive primary research and is linked to multiple publications), explores NHS midwives who do provide respectful midwifery care even when those choices are deemed ‘not recommended’. The book highlights the key tenets of the midwifery practice and illustrates insights as to how to provide care that is aligned with human rights, authentic consent, equality and includes information about their professional accountability. The book finishes with insights regarding Trust/organisation responsibilities where the key message is for midwives to work to their full scope of practice (to deliver all 56 improved maternal-neonatal outcomes), aligned with legal and ethical frameworks they must work within ‘enabling environments’ and supported to deliver this type of care.

Furness, A., Fair, F., Higginbottom, G., Oddie, S. and Soltani, H. (2024) ‘A review of policies and guidance on Apgar scoring and detection of jaundice and cyanosis in Black, Asian and ethnic minority neonates’, BMC Pediatrics, 24(1), Article 198. doi:10.1186/s12887-024-04613-9.

Annotation:

This review analyses UK and international clinical guidance relating to neonatal assessment and skin-tone-dependent indicators. It identifies gaps in how diversity is addressed within standards, training, and guidance, with implications for delayed recognition of clinical deterioration. The Collective used this paper in discussion to illustrate how structural omissions in policy and education can translate into unequal safety outcomes at the start of life.

Nursing and Midwifery Council (NMC) (2024) The professional duty of candour. London: NMC.

Annotation:

This guidance sets out openness, honesty, and learning from harm as professional obligations for nurses and midwives. It clarifies expectations for responding to adverse events, including communication with those affected and organisational learning. The Collective used this document to reinforce that defensive practice, silence, or failure to acknowledge harm is incompatible with professional standards and safe maternity care.

Pickles, C. (2023) ‘“Obstetric violence”, “mistreatment”, and “disrespect and abuse”: reflections on the politics of naming violations during facility-based childbirth’, Hypatia, 38(3), pp. 628–649. doi:10.1017/hyp.2023.73.

Annotation:

This paper, written by a leading expert academic of Obstetric Violence (OV), explores the importance of 'naming' the phenomenon of OV. Challenging and exploring the different terminology used for poor maternity care such as disrespect and abuse of mistreatment, Pickles argues that the healthcare sector should not be the group to formulate terms and definitions given their role in perpetuating harm.

Rutter, T., Hastings, R., Enoch, N., Flynn, S., Randell, M. and Stinton, C. (2025) ***Down syndrome in maternity care: Mothers' experiences of prenatal screening*****.** ***American Journal of Medical Genetics Part A*****, e64206. Available at: https://doi.org/10.1002/ajmg.a.64206 (Accessed: 18/02/2026).**

Annotation

This paper examines mothers' experiences of prenatal screening for Down syndrome in UK maternity services. Many participants reported insufficient information, limited support in interpreting results, and non-neutral communication, including interactions perceived as reflecting negative assumptions about Down syndrome. The authors highlight the importance of personalised discussion, neutral presentation of results, and legitimising the option to decline screening. The study informed the Collective's emphasis on informed decision-making and autonomy within screening pathways, recognising how the framing of care-based conversations can shape understanding, trust, and choice.

Rutter, T., Hastings, R., Enoch, N., Flynn, S., Randell, M. and Stinton, C. (2025) ***Down syndrome in British maternity care: Mothers' experiences of prenatal testing and receiving a prenatal or postnatal diagnosis*****. Journal of Applied Research in Intellectual Disabilities, e70160. Available at: https://doi.org/10.1111/jar.70160 (Accessed: 18/02/2026).**

Annotation:

Rutter *et al*. (2025) explore mothers' experiences of prenatal testing and of receiving either a prenatal or postnatal diagnosis of Down syndrome within UK maternity services. The study examines how information was communicated, how diagnoses were delivered, and the emotional and practical support offered. Participants described variability in the sensitivity, balance, and adequacy of communication at the point of diagnosis. The findings informed the Collective's emphasis on compassionate and balanced communication in all care-based conversations, particularly diagnostic ones, recognising how these interactions shape trust, autonomy, and families' longer-term experiences of care.

Šimonović, D. (2019) A human rights-based approach to mistreatment and ***National Maternity and Neonatal Collective:*** *Prioritising safe, equitable, compassionate, human-rights centred care for all service users and staff; centring the needs of Black and brown women and birthing people, along with those from other marginalised communities.*

violence against women in reproductive health services, with a focus on childbirth and obstetric violence (UN Doc. A/74/137). New York: United Nations General Assembly. Available at: https://digitallibrary.un.org/record/3823698 (Accessed: 05/01/2026).

Annotation:

This report, submitted by the UN Special Rapporteur on Violence against Women, analyses how mistreatment and obstetric violence in reproductive health services, including facility-based childbirth, constitute violations of women's human rights under international law. It documents forms of abuse, from physical and verbal mistreatment to coercion and lack of informed consent, and situates these within obligations to respect dignity, equality, bodily integrity, and freedom from cruel, inhuman or degrading treatment. The Collective used this rights-based framing to support the position that patterns of disrespect and coercion in maternity care require legal and system-level responses rather than being treated as quality issues.

World Health Organization (WHO) (2014) The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. Geneva: WHO. Available at: https://apps.who.int/iris/handle/10665/134588 (Accessed: 05/01/2026).

Annotation:

This WHO statement recognises disrespect and abuse during childbirth as a global health and human rights issue. It calls for policy, accountability, training, and community engagement to prevent mistreatment in maternity services. The Collective used this statement to ground its emphasis on respectful maternity care within internationally recognised safety and rights frameworks.

Systems of marginalisation: conceptual foundations

Methodological positioning

This section sets out the frameworks used to understand how marginalisation operates within maternity care. These approaches focus on systems of power rather than individual identity, and explain why harm is patterned rather than random.

Intersectionality

Crenshaw, K. (1989) 'Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics'. University of Chicago Legal Forum, 1989(1), pp. 139–167.

AND

Crenshaw, K. (1991) ‘Mapping the margins: Intersectionality, identity politics, and violence against women of color’. Stanford Law Review, 43(6), pp. 1241–1299.

Annotation:

Intersectionality provides a way of understanding how overlapping forms of oppression shape experience and risk. It explains why single-issue approaches to inequality routinely fail, and why maternity services that do not account for intersecting disadvantage will continue to overlook those most at risk. The Collective used this understanding of systems of marginalisation as a scaffold for discussions, enabling its participants to explore how these systems interact to shape maternal health outcomes.

Reproductive Justice

Ross, L.J. and Solinger, R. (2017) Reproductive justice: An introduction. Oakland, CA: University of California Press.

Annotation:

The reproductive justice framework situates pregnancy and birth within broader conditions of autonomy, safety, and social support. It supports the Collective’s insistence that maternity care cannot be separated from questions of rights, dignity, and the ability to parent without harm or surveillance.

Social determinants of health and structural racism

World Health Organization (WHO) (2008) Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

Bailey, Z.D., Krieger, N., Agénor, M., Graves, J., Linos, N. and Bassett, M.T. (2017) Structural racism and health inequities in the USA: Evidence and interventions. The Lancet, 389(10077), pp. 1453–1463.

Annotation:

These frameworks demonstrate how health outcomes are shaped by social and political conditions, including poverty, housing, migration status, and institutional racism. Their relevance lies in shifting attention away from individual behaviour and

toward the systems that produce unequal risk and unequal care.

Further reading:

Roberts, D.E. (2017) Killing the Black body: Race, reproduction, and the meaning of liberty. New York, NY: Vintage Books.

Vedam, S., Stoll, K., Taiwo, T.K., Rubashkin, N., Cheyney, M., Strauss, N., McLemore, M., Cadena, M., Nethery, E., Rushton, E., Schummers, L. and Declercq, E. (2019) The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reproductive Health, 16(1), Article 77.

Equity, racism, and unequal outcomes and experiences

Angeli, F., Gamberini, C., and Ambrosino, E. (2024). "This Should Be the Answer!": The Evolution of Relational Dynamic Capabilities in the Co-Production of Maternity Care Services to Vulnerable Women. Qualitative Health Research.

Annotation:

As an example of best practice, this research paper explores a 20-year service of a community-based antenatal and postnatal continuity midwifery team called 'HAAMLA' in Leeds. This service was designed and delivered to address the specific needs and higher risk of adverse outcomes of the most vulnerable women within the area (e.g., Asylum seekers, isolated refugees, English/Irish Gypsy Traveller and other vulnerable ethnic minority groups and those experiencing domestic violence, lone motherhood, or homelessness etc.). Crucially, this service, through time and intentional effort, was not only fully integrated into the overall maternity organisation of their employment but cultivated very close partnerships with third sector organisations and other statutory services (housing, social services, interpreter services, Home Office, etc.), offering a bespoke multi-disciplinary service helping service users get their needs met beyond that solely related to maternity care itself. Such a holistic approach, with consistent known continuity midwives was identified as the key elements of their success in mitigating health disparities.

Aryasinghe, S. et al. (2025) 'Improving the maternity experience for Black, African, Caribbean and mixed-Black families in an integrated care system', BMJ Quality & Safety, 34(5), pp. 305–316. doi:10.1136/bmjqs-2024-017890.

Annotation:

Highlighting another example of reaching minority communities, this research paper is a co-produced service improvement prioritisation plan for Black, African, Caribbean and mixed-Black families to address health disparities across an Integrated Care System (ICS) comprising of 10 maternity organisations. Unique to this study was the integrated approach under one ICS that included health and local authority perspectives, Voluntary, Community, and Social Enterprise (VCSE) sector and the public to explore what the communities wanted to prioritise to address the health inequalities. With 54 attendees they generated 89 potential interventions across 11 themes (respect for person-centred care, information; education, advocacy mechanisms, mental health, involvement of friends and family, access, staff knowledge and capabilities, ethnicity-based safety risks, organisational policies, community partnerships, coordination; integration of care). All attendees prioritised improving staff knowledge and capacity in culturally competent care and communication. Further research is underway to implement and evaluate the priority interventions.

Fair, F., Soltani, H., Raben, L., van Streun, Y., Sioti, E., Papadakaki, M. and Vivilaki, V. (2021) 'Midwives' experiences of cultural competency training and providing perinatal care for migrant women', BMC Pregnancy and Childbirth, 21(1), 340. doi:10.1186/s12884-021-03741-3.

Annotation:

This mixed-methods study explores midwives' experiences of providing care to migrant women following cultural competency training. It shows that training can increase awareness but has limited impact when organisational constraints and service fragmentation persist. The Collective used this to inform discussions about equity requiring system-level support, not training alone.

Fair Access Scotland (2026) *Care experienced definition*. Available at: https://www.fairaccess.scot/connect/care-experienced/ (Accessed: 06/02/2026).

Annotation:

Fair Access Scotland defines care experienced as referring to anyone who has been, or is currently, in care or from a looked-after background at any stage in their life, regardless of the length of time, including those previously looked after such as adopted individuals and those cared for in residential care, foster care, kinship care or being looked after at home with a supervision requirement. This definition informed the Collective's understanding of who is considered care experienced within the context of widening access and equity, and it was adopted in the Collective's report to ensure consistency in identifying and discussing care

experienced individuals across analysis and recommendations.

Five X More (2022) Black maternity experiences survey and policy report. London: Five X More.

Annotation:

This community-led report documents the experiences of Black women navigating UK maternity services, drawing on survey and qualitative evidence. It identifies recurring patterns of dismissal, stereotyping, and unequal treatment that sit behind observed disparities in outcomes. The Collective used this report to ground national surveillance data in lived experience and as a means of understanding how inequity is actively produced within care encounters.

Harrison, S., Alderdice, F., Fellmeth, G. and Quigley, M.A. (2025) 'Inequalities in childbirth experiences in England', NIHR Open Research, 5, 31. doi:10.3310/nihropenres.13472.1.

Annotation:

This study analyses national survey data to examine inequalities in women's experiences of childbirth in England. It shows that differences in experience such as not being listened to or treated with respect are patterned by ethnicity, deprivation, and other social factors. The Collective used this evidence to understand how experience and safety are interlinked, and inequity can be embedded in everyday care interactions.

LGBT Foundation (2022) *Trans & Non-Binary Experiences of Maternity Services (ITEMS report)*. LGBT Foundation. Available at: https://dxfy8lrzbpywr.cloudfront.net/Files/97ecdaea-833d-4ea5-a891-c59f0ea429fb/ITEMS%2520report%2520final.pdf (Accessed: 04/02/2026).

Annotation:

This report, produced by the LGBT Foundation as part of the *Improving Trans and Non-Binary Experiences of Maternity Services (ITEMS)* project, presents findings from a UK-based survey and interviews exploring the maternity care experiences of trans and non-binary birthing parents. It highlights extensive evidence of disparities in access, respect, dignity, information provision and support compared with the wider population, including notable rates of engagement with perinatal services being avoided entirely due to previous negative experiences and fears of mistreatment. Central themes include the impacts of misgendering, non-inclusive language, systemic invisibility within care pathways, and the intersections of

transphobia and racism in shaping these lived experiences. Drawing on both quantitative and qualitative data, the report also offers a set of targeted recommendations for commissioners, policymakers and healthcare professionals to improve inclusivity and safety within maternity services. The report informed the Collective's understanding of trans and non-binary experiences within maternity services by providing detailed, evidence-based insights into the barriers that trans and non-binary people face at all stages of perinatal care. Its findings supported the Collective's recognition of the need for gender-inclusive practice, inclusive terminology, and service design that actively addresses discrimination and improves access and outcomes for trans and non-binary birthing parents.

MBRRACE-UK (2024) Saving lives, improving mothers' care. Oxford: National Perinatal Epidemiology Unit.

Annotation:

This confidential enquiry report provides national surveillance data on maternal deaths and morbidity in the UK, including persistent disparities by ethnicity and deprivation. The continuation of these inequalities over successive reporting cycles indicates structural failure rather than lack of awareness or data. The Collective used this report as a benchmark for assessing progress on equity and as evidence that repeated recognition has not translated into sufficient system change.

MBRRACE-UK (2025) Maternal mortality in the UK 2021–2023. Oxford: National Perinatal Epidemiology Unit.

Annotation:

Updated surveillance data confirm that ethnic disparities in maternal death have not been resolved. The Collective used this report as further evidence of the need for structural, rather than awareness-based, responses.

Sharma, E., Puthussery, S., Tseng, P., Harden, A. and Li, L. (2023) 'Development, acceptability and feasibility of a community-based intervention to increase timely initiation of antenatal care', Midwifery, 126, 103812. doi:10.1016/j.midw.2023.103812.

Annotation:

This research paper highlights more best practice through a co-produced community-based intervention to increase uptake of early antenatal care in an area with high ethnic diversity and low socio-economic status. Earlier initiation of antenatal care is associated with improved outcomes and experiences; however,

research demonstrated in some marginalised communities ‘later’ antenatal care initiation was the norm (for a range of complex reasons), therefore, this intervention was designed to address health disparities for these communities. The researcher developed the intervention via co-production workshops and conversations with 20 local service users from diverse ethnic backgrounds and 14 stakeholders. The intervention comprised of training ‘Antenatal Care Champions’ to deliver co-designed promotional information (translated into Bengali, Urdu, Polish, and Romanian) and a co-designed script in local areas of high footfall and community organisations. Thus, serving as a novel ‘outreach’ programme that sought to meet women and families within everyday community spaces to increase knowledge and awareness of initiating earlier antenatal care, and importantly, how to initiate care (information regarding systems and processes was provided.)

Stevenson, K. et al. (2024) ‘Public health, policy, and clinical interventions to improve perinatal care for migrant women and infants in high-income countries’, eClinicalMedicine, 78, 102938. doi:10.1016/j.eclinm.2024.102938.

Annotation:

This systematic review synthesises evidence on public health, policy, and clinical interventions aimed at improving perinatal care for migrant women and infants in high- income countries. It highlights how fragmented services, insecure immigration status, language barriers, and exclusionary policies are associated with poorer access, experience, and outcomes, and identifies approaches such as continuity of care, culturally responsive services, and improved coordination as features of interventions linked to better engagement and safety. In this report, the review informed the Collective’s thinking about how structural and policy environments shape maternity care for migrant women. Read alongside lived experience and other evidence, it contributed to discussion about why maternity systems must explicitly consider migration status, language needs, and structural exclusion, rather than treating these as individual or peripheral issues.

Trauma-informed care, perinatal mental health, and bereavement

De Backer, K., Pali, A., Challacombe, F.L., Hildersley, R., Newburn, M., Silverio, S.A., Sandall, J., Howard, L.M. and Easter, A. (2024) ‘Women’s experiences of attempted suicide in the perinatal period (ASPEN study): a qualitative study’, BMC Psychiatry, 24(1), 255. doi:10.1186/s12888-024-05686-3.

Annotation:

This qualitative study explores women’s experiences of attempted suicide during pregnancy and the postnatal period, focusing on distress, help-seeking, and

interactions with services. It identifies unmet mental health needs, fragmented care, fear of judgement, and concerns about safeguarding consequences as contributing factors. The Collective used this study to support an understanding of perinatal suicide risk as relational and systemic rather than individual, reinforcing the need for trauma-informed and coordinated care.

Webb, R. et al. (2023) 'Meta-review of the barriers and facilitators to women accessing perinatal mental healthcare', BMJ Open, 13(7), e066703. doi:10.1136/bmjopen-2022-066703.

Annotation:

This meta-review synthesises findings from existing reviews on access to perinatal mental healthcare. It identifies barriers including stigma, fear of judgement, fragmented pathways, inconsistent identification of need, and variable service availability, alongside facilitators such as continuity and compassionate communication. The Collective used this evidence to understand how policy intent may not reliably translate into access and why system design is central to effective mental healthcare.

Cibralic, S., Pickup, W., Diaz, A.M., Kohlhoff, J., Karlov, L., Stylianakis, A., Schmied, V., Barnett, B. and Eapen, V. (2023) 'The impact of midwifery continuity of care on maternal mental health: a narrative systematic review', Midwifery, 116, 103546. doi:10.1016/j.midw.2022.103546.

Annotation:

This systematic review included 8 primary researchers exploring the role of MCoC upon maternal mental health. The authors reported that midwifery continuity of care leads to improvements in maternal anxiety/worry and depression during the perinatal period.

NHS England (2018) Perinatal mental health care pathways. London: NHS England.

Annotation:

This policy document sets out intended pathways for perinatal mental health care across maternity, primary care, and specialist mental health services. It articulates expectations for coordination, referral, and continuity. The Collective used this document to highlight the gap between policy design and the fragmented care many women and birthing people experience in practice.

National Institute for Health and Care Excellence (NICE) (2014, updated)

National Maternity and Neonatal Collective: *Prioritising safe, equitable, compassionate, human-rights centred care for all service users and staff; centring the needs of Black and brown women and birthing people, along with those from other marginalised communities.*

Antenatal and postnatal mental health: clinical management and service guidance (CG192). London: NICE.

Annotation:

This guideline establishes that perinatal mental health is a core component of maternity care. Where support is fragmented or inaccessible, this reflects system design choices rather than individual need or resilience.

Robinson, K., Due, C., Briley, A. and Loughnan, S.A. (2025) 'Midwifery continuity of care in a subsequent pregnancy after perinatal loss: a scoping review of qualitative evidence', BJOG: An International Journal of Obstetrics & Gynaecology. doi:10.1111/1471-0528.70112.

Annotation:

This scoping review found four primary research studies that had explored the role of MCoC following a previous bereavement. While only four studies, the authors reported that trauma- informed, compassionate care principles found in MCoC show significant potential to support bereaved parents and psychosocial wellbeing in pregnancy after loss.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) SAMHSA's concept of trauma and guidance for a trauma-informed approach. Rockville, MD: SAMHSA.

Annotation:

This framework defines trauma-informed care as an organisational responsibility rather than an individual skill. Its relevance lies in shifting maternity care away from control and compliance toward safety, trust, and the avoidance of re-traumatisation.

Webb, R. et al. (2024) Conceptual framework on barriers and facilitators to implementing perinatal mental health care and treatment for women: the MATRIx evidence synthesis. Health and Social Care Delivery Research, 12(2), pp. 1–187. doi:10.3310/KQFE0107.

Annotation:

This evidence synthesis develops a conceptual framework identifying factors that may influence the implementation of perinatal mental health care across maternity, primary care, and mental health services. Drawing on a range of qualitative and quantitative evidence, it highlights potential barriers including fragmented pathways, limited workforce capacity, inconsistent training, and organisational cultures that may

inhibit trust and disclosure. It also identifies facilitators such as continuity, clear referral routes, compassionate communication, and system-level leadership. For the Collective it framed understanding of why well- intentioned perinatal mental health policies may not translate into consistent practice and supported discussion about the need for coordinated, trauma-informed, and adequately resourced systems.

Models of care, continuity, and midwifery-led provision

Byrom, A., Thomson, G., Akooji, N. and Feeley, C. (2025) 'Sustaining continuity of carer in practice: a service evaluation of a local maternity system in Northwest England', Midwifery, 150, 104603. doi:10.1016/j.midw.2024.104603.

Annotation:

This study was an evaluation of the implementation of MCoC across the Northwest of England which included four NHS Trusts. Interviews with midwives revealed their lived experiences of the early adoption, implementation and in some cases sustained MCoC. The midwives valued the care model and found they were better placed to develop meaningful reciprocal relationships with those in their care, more able to detect and act on emerging issues and provide meaningful personalised care. Among many findings, the researchers found MCoC worked well when supported by Trust leadership, ring-fenced and protected time (e.g., not used as escalation into the maternity units) and crucially, where midwives were in control of their diaries. However, the converse was also true, midwives in this model were more at risk of burnout when they were used to cover staffing shortfalls within the maternity units, unable to control their own diaries or work flexibly and if leadership or the wider Trust team did not support their role. Additionally, they found issues regarding the increased rate of induction of labour with uncertainty around the best way to provide continuity within this model of 'following the women' irrespective of their birthplace. Greater thought and planning need to take this into consideration.

Hutton, E.K., Reitsma, A., Simioni, J., Brunton, G. and Kaufman, K. (2019) 'Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital', EClinicalMedicine, 14, pp. 59–70. doi:10.1016/j.eclinm.2019.07.005.

AND

Reitsma, A., Simioni, J., Brunton, G., Kaufman, K. and Hutton, E.K. (2020) 'Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital', EClinicalMedicine, 21, 100319.

doi:10.1016/j.eclinm.2020.100319.

Annotation:

These two meta-analyses, the largest to date, included 500,000 'healthy low risk' mother-baby dyads exploring their outcomes of those who planned to birth at home while comparing them to those who planned to birth at hospital. All studies that were included were all based in high-income countries with qualified midwives as the lead carers. Overall, the studies found that homebirth was a safe option particularly for those contexts where homebirth and the midwives were well integrated into maternity services, with timely access to emergency and medical care if required. For perinatal/neonatal mortality the researchers reported that the risk of perinatal or neonatal mortality was not different when birth was intended at home or in hospital. For maternal outcomes (there was no maternal deaths in this dataset), they reported those planning a homebirth were less likely to have a caesarean section; operative vaginal birth; epidural analgesia; episiotomy; 3rd or 4th degree tear; oxytocin augmentation; or maternal infection.

Fernández Turienzo, C., Rayment-Jones, H., Roe, Y., Silverio, S.A., Coxon, K., Shennan, A.H. and Sandall, J. (2021) 'A realist review to explore how midwifery continuity of care may influence preterm birth', Birth, 48(4), pp. 468–483. doi:10.1111/birt.12547.

Annotation:

This realist review explores the mechanisms through which midwifery continuity of care may influence the risk of preterm birth, focusing on how and why continuity might work in particular contexts rather than whether it is universally effective. It identifies potential pathways including improved trust, earlier identification of concerns, more consistent monitoring, better communication, and enhanced engagement with care, particularly for women experiencing social or clinical vulnerability. The review emphasises that outcomes are shaped by context, relationships, and system design, rather than continuity operating as a simple intervention. The review informed the Collective's understanding of continuity of care as a relational and contextual mechanism that may contribute to improved outcomes for some groups, reinforcing the importance of designing continuity models that are responsive to complexity, inequality, and differing needs rather than assuming uniform effects across all populations.

Khan, Z.A., Vowles, Z., Fernandez Turienzo, C., Barry, Z., Brigante, L., Downe, S., Easter, A., Harding, S., McFadden, A., Montgomery, E., Page, L., Rayment-Jones, H., Renfrew, M., Silverio, S.A., Spiby, H., Villarroel-Williams, N. and Sandall, J. (2023) 'Targeted health and social care interventions for women and

infants disproportionately impacted by health inequalities in high-income countries', International Journal for Equity in Health, 22, 131. doi:10.1186/s12939-023-01948-6.

Annotation:

This systematic review examines targeted health and social care interventions designed to support women and infants who experience disproportionate health inequalities in high- income countries. It identifies a range of approaches, including continuity-based models, community-embedded care, enhanced social support, and multidisciplinary interventions, and explores how these may influence access, engagement, experience, and selected outcomes. The review highlights that interventions tailored to structural and social risk factors may be more acceptable and accessible than standardised models of care, while also noting variation in design, delivery, and evidence quality. The review informed the Collective's understanding of why models of care that are intentionally designed around the needs of marginalised communities may offer advantages over universal approaches alone. It contributed to discussion about continuity of care and targeted provision as features of equity-oriented maternity systems.

Khan, Z.A., Turienzo, C.F., Rayment-Jones, H., Vowles, Z., Harding, S. and Sandall, J. (2025) 'Women's experiences of community-based midwifery continuity of care in South London: a longitudinal intersectional study', Women and Birth, 39(1), 102137. doi:10.1016/j.wombi.2025.102137.

Annotation:

This longitudinal qualitative study explores women's experiences of community-based midwifery continuity of care, using an intersectional lens to examine how social position, ethnicity, migration status, and other forms of marginalisation shape engagement with care. It highlights how continuity of relationships can support trust, communication, and navigation of services, while also showing that benefits are not evenly experienced and are influenced by wider structural and organisational factors. The study informed the Collective's understanding of how continuity of care is experienced in practice, reinforcing that relational models may be particularly valued by women and birthing people facing multiple forms of disadvantage, but that their effectiveness depends on context, resourcing, and system design. It contributed to discussion about why continuity of care should be implemented in ways that are attentive to inequality and lived experience, rather than assumed to function uniformly across populations.

Kuipers, Y., Aitken-Arbuckle, A., Jenkins, H., Watson, S., King, M. and Zemouri, C. (2025) 'Midwife continuity of care: a systematic review and meta-analysis of

case-control and cohort studies', International Journal of Nursing Studies, 174, 105300. doi:10.1016/j.ijnurstu.2025.105300.

Annotation:

This systematic review and meta-analysis of non-randomised cohort and case-control studies shows that midwife continuity of care is associated with improved labour and birth outcomes (including higher rates of spontaneous vaginal birth and lower intervention rates) and favourable maternal and neonatal results. It synthesises evidence that continuity models confer benefits across clinical and experiential domains, reinforcing the argument that relational continuity is a protective measure for women and birthing people, particularly those experiencing multiple marginalisation. This review was used in the report to contextualise and affirm the Collective's emphasis on continuity of midwifery care as a protective, relational model at system level.

Parslow, E. and Rayment-Jones, H. (2024) 'Birth outcomes for women planning vaginal birth after caesarean (VBAC) in midwifery-led settings', Midwifery, 104168. doi:10.1016/j.midw.2024.104168.

Annotation:

This systematic review and meta-analysis synthesises evidence on birth outcomes for women planning vaginal birth after caesarean (VBAC) in midwifery-led settings. It reports that, for appropriately selected women, planned VBAC in midwifery-led settings is associated with high rates of vaginal birth and low rates of adverse maternal and neonatal outcomes, within the limits of the available evidence. The review also highlights the importance of clear eligibility criteria, timely access to transfer, and robust clinical governance. It was used in Collective discussions to demonstrate how models of care and setting might shape intervention rates and experiences for women and birthing people planning VBAC.

Rayment-Jones, H., Dalrymple, K., Harris, J., Harden, A., Parslow, E., Georgi, T. and Sandall, J. (2021) 'Does continuity of care and community-based antenatal care improve maternal and neonatal birth outcomes for women with social risk factors?', PLOS ONE, 16(5), e0250947. doi:10.1371/journal.pone.0250947.

Annotation:

This study based in England, aimed to compare maternal and neonatal clinical birth outcomes for 1000 women with social risk factors accessing different models of maternity care. The research highlighted how community-based antenatal care, with a focus on Continuity of Carer reduced health inequalities and improved maternal

and neonatal clinical outcomes for women with social risk factors. The findings support the current policy drive to increase continuity of midwife-led care, whilst adding that community-based care may further improve outcomes for women and birthing people at increased risk of health inequalities. Read alongside lived experience and other evidence on inequality in maternity services, it contributed to the Collective's reflections on continuity of care.

Rayment-Jones, H., Harris, J., Harden, A., Silverio, S. A., Turienzo, C. F. and Sandall, J. (2022) Project20: Maternity care mechanisms that improve (or exacerbate) health inequalities. A realist evaluation. Women and Birth, 36(3), e314–e327. doi:10.1016/j.wombi.2022.11.006.

Annotation:

This realist evaluation explores how different maternity care models operate through underlying mechanisms that can either reduce or exacerbate health inequalities. Focusing on women with social risk factors, it highlights the importance of relational continuity, trust, and context-responsive care in enabling engagement, disclosure, and safety, while showing how fragmented or inflexible services can reinforce stigma and exclusion. The findings informed the Collective's thinking about how maternity systems shape experience and outcomes, supporting an emphasis on continuity, relationship-based care, and service design that actively mitigates, rather than reproduces, structural disadvantage - particularly important in the context of prioritising Black, brown and marginalised communities.

Rayment-Jones, H., Dalrymple, K., Harris, J. M., Harden, A., Parslow, E., Georgi, T., and Sandall, J. (2023). Project20: Maternity care mechanisms that improve access and engagement for women with social risk factors in the UK – A mixed-methods, realist evaluation. BMJ Open, 13(2). https://bmjopen.bmj.com/content/13/2/e064291

Annotation:

This mixed-methods realist evaluation examines how and why particular models of maternity care influence access to and engagement with services for women with social risk factors in the UK. Rather than focusing solely on outcomes, the study identifies mechanisms such as continuity of relationship, trust, flexibility, community-based provision, and advocacy that may enable women to engage more consistently with care, particularly where experiences of exclusion or marginalisation are present. It also highlights how organisational context, staffing, and service configuration shape whether these mechanisms are realised in practice. The study informed the Collective's discussions about how maternity services can be designed to reduce barriers to access and engagement, reinforcing the importance of

relational, continuity-based, and community-embedded models of care for women and birthing people facing multiple forms of disadvantage. It contributed to the Collective's understanding that inequitable access is not primarily a matter of individual behaviour, but is shaped by how services are structured, resourced, and delivered.

Renfrew, M.J., McFadden, A., Bastos, M.H., Campbell, J., Channon, A.A., Cheung, N.F., Silva, D.R.A.D., Downe, S., Kennedy, H.P., Malata, A., McCormick, F., Wick, L. and Declercq, E. (2014) Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. The Lancet, 384(9948), pp. 1129–1145.

Annotation:

This landmark paper, published as part of The Lancet Midwifery Series, synthesises global evidence on what constitutes high-quality maternal and newborn care. Drawing on 176 quantitative meta-analyses and 27 qualitative evidence syntheses, it demonstrates that safety, equity, and positive outcomes are achieved through relationship-based, respectful, continuous care delivered by skilled midwives working within supportive systems. The Series reframed midwifery-led care not as a workforce preference but as a public health intervention, showing that fragmentation, over-medicalisation, and hierarchical models can undermine quality and safety. For the Collective, this paper functioned both as empirical evidence and as an anchor: it underpins the argument that midwifery-led, relational models are foundational to safe maternity systems, and that system design determines whether high-quality care can be delivered.

Roebuck, C., Sandall, J., West, R., Atherden, C., Parkyn, K., and Johnson, O. (2025). Impact of midwife Continuity of Carer on stillbirth rate and first feed in England. Communications Medicine, 5(1), 339.

Annotation:

This population-based study used NHS Maternity Services Dataset records for 922,149 women in England to examine whether placement on a midwife Continuity of Carer pathway by 24 weeks' gestation was associated with differences in stillbirth rates and breastfeeding initiation, compared with standard care. Across all demographic groups, women receiving Continuity of Carer had higher rates of first breast milk feed, while no overall difference in stillbirth rates was observed. However, among Black women, lower stillbirth rates were observed for those on a Continuity of Carer pathway compared with those receiving standard care. Within the Collective's discussions, this study was not treated as evidence of causation, but as part of a wider body of learning that informed thinking about the potential importance of

continuity of care for groups facing known inequities. Read alongside lived experience and other evidence, it contributed to reflection on why maternity policy and service design should pay particular attention to Black, brown, and other marginalised communities, rather than relying on universal approaches alone.

Sandall, J., Fernández Turienzo, C., Devane, D., Soltani, H., Jones, L., Shennan, A., Gates, S., Gillespie, P. and Rayment-Jones, H. (2024) 'Midwife continuity of care models versus other models of care for childbearing women', Cochrane Database of Systematic Reviews, Issue 2, CD004667. doi:10.1002/14651858.CD004667.pub6.

Annotation:

This Cochrane review synthesises evidence comparing midwife continuity of care models with other models of maternity care across pregnancy, birth, and the postnatal period. It finds that women receiving continuity of midwifery care are less likely to experience caesarean section or instrumental birth and more likely to have a spontaneous vaginal birth, alongside improved experiences of care, including greater satisfaction and involvement in decision-making. The review also highlights that benefits are evident for women and birthing people facing social or structural disadvantage. For the Collective, this review was not treated as evidence of continuity as a discrete intervention, but as evidence of continuity as a relational and organisational feature of safe maternity systems. Read together with evidence on staffing, workforce sustainability, and inequity, it informed discussion about why continuity of care may act as a protective factor for marginalised groups, while underscoring that such models require adequate staffing, leadership, and system support to function safely and sustainably.

Tikkanen, R., Gunja, M.Z., FitzGerald, M. and Zephyrin, L. (2024) Insights into the U.S. maternal mortality crisis: An international comparison. New York: Commonwealth Fund.

Annotation:

This international comparison highlights that countries with strong, integrated midwifery systems and continuity-based models have better maternal outcomes than those dominated by fragmented, obstetric-led care. While focused on the U.S., its relevance here lies in reinforcing that system design, not clinical capability alone, shapes safety, equity, and sustainability.

Vowles, Z., Lovell, H., Black, M., Sandall, J., and Easter, A. Models of care for pregnant women with multiple long-term conditions and the role of the midwife: A scoping review. Women Birth. 2024 Sep;37(5):101645. doi:

10.1016/j.wombi.2024.101645. Epub 2024 Jul 15. PMID: 39013274.

Annotation:

This scoping review maps existing models of care for pregnant women with multiple long-term conditions, with focus on the role of the midwife within complex, multidisciplinary systems. It identifies considerable variation in how care is organised, alongside gaps in continuity, coordination, and clarity of responsibility across services. The review highlights that women with multiple long-term conditions often experience fragmented care and repeated reassessment, and that midwives may play a key role in coordination, advocacy, and relationship-building where continuity is supported. The review informed the Collective's understanding of how models of care can either mitigate or exacerbate complexity for women and birthing people with higher clinical and social needs. It contributed to discussion about the importance of continuity, coordination, and relational care in supporting safety and informed decision-making.

Accessibility, interpretation, and communication

Dasgupta, T., Rayment-Jones, H., Horgan, G., Begum, Y., Peter, M., Silverio, S.A., and Magee, L.A. Understanding care-seeking of pregnant women from underserved groups: A systematic review and meta-ethnography. Frontiers in Public Health. 2025 Nov 20;13:1683740.

Annotation:

This systematic review and meta-ethnography synthesises qualitative evidence on how pregnant women from underserved groups understand, navigate, and seek maternity care. It identifies how experiences of discrimination, fear of judgement or surveillance, language barriers, past trauma, and mistrust of services may shape decisions about when, how, or whether to engage with care. The synthesis also highlights facilitators of engagement, including respectful relationships, continuity, culturally safe communication, and services that are accessible and responsive to lived context. The review supports the Collective's view that maternity systems must be designed to reduce fear, exclusion, and power imbalance if they are to be genuinely accessible and safe for those most at risk of poor outcomes.

Furness, A., De Vivo, M., and Soltani, H. (2025). Facilitators and barriers for adapting physical activity during the perinatal period by women from marginalised backgrounds. British Journal of Midwifery.

Annotation:

National Maternity and Neonatal Collective: *Prioritising safe, equitable, compassionate, human-rights centred care for all service users and staff; centring the needs of Black and brown women and birthing people, along with those from other marginalised communities.*

This qualitative study explores how women from marginalised backgrounds experience and navigate opportunities for physical activity during the perinatal period, identifying a range of social, cultural, environmental, and service-related barriers and facilitators. It highlights how factors such as poverty, caring responsibilities, safety concerns, lack of accessible information, and inflexible or poorly designed services may limit engagement, while trusted relationships, culturally appropriate support, and locally accessible provision may enable participation. For the Collective its relevance was in illustrating how service design that fails to account for structural inequality and lived context can inadvertently exclude some women and birthing people.

Furness, A., Salmon, A., Fair, F., and Soltani, H. (2025). Exploring research and healthcare priorities in maternal health: A qualitative ethnographic study with mothers from ethnic minority backgrounds in the UK. European Journal of Midwifery, 9, 10-18332.

Annotation:

This qualitative ethnographic study explores how mothers from ethnic minority backgrounds in the UK identify priorities for maternal health research and healthcare, drawing attention to gaps between service design and lived experience. Participants highlight the importance of accessible information, respectful communication, continuity, cultural safety, and practical support, alongside concerns about being listened to and taken seriously within healthcare encounters. The study's relevance to the Collective lies in making visible how service priorities and structures may fail to reflect the needs and experiences of those most affected by inequity. It supports the argument that inclusive and accessible maternity care requires meaningful engagement with diverse communities.

NHS England (2025a) Accessible Information Standard (DAPB1605). London: NHS England.

Annotation:

The Accessible Information Standard establishes communication support as a legal requirement. Failure to meet these needs constitutes a safety and equality breach, not an inconvenience or optional adjustment.

NHS England (2025b) Community language translation and interpreting services framework. London: NHS England.

Annotation:

This framework makes explicit that interpreting and translation are foundational to informed consent and safe care. Without them, equity and autonomy cannot be realised in practice.

Rayment-Jones, H., Harris, J., Harden, A., Silverio, S. A., Turienzo, C. F., and Sandall, J. (2021). Project20: Interpreter services for pregnant women with social risk factors in England – What works, for whom, in what circumstances, and how? International Journal for Equity in Health, 20(1), 1–11. https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-021-01570-8 (Accessed: 16/01/2026)

Annotation:

This realist evaluation examines the role of professional interpreter services in supporting access to and engagement with maternity care for pregnant women with social risk factors in England. It identifies mechanisms through which interpreting may enable safer and more effective care, including improved communication, trust, informed decision-making, and continuity, while also highlighting how inconsistent availability, reliance on informal interpreters, and organisational constraints can undermine these benefits. The study emphasises that interpreter services function as a core component of care infrastructure rather than an optional add-on. In this report, the findings informed the Collective's discussions about accessibility, consent, and equity, reinforcing the view that language support is integral to safe, rights-respecting maternity care and must be embedded within service design and resourcing.

Rayment-Jones, H., Mohamud, Y., Lovell, H., Rankin, J., Sandall, J., Peeren, S., Dube, M., Hector-Jack, N.S., Barry, Z., Turienzo, C.F. and Sowah, E., 2025. Maternal and early childhood health and social outcomes of migrants in high-income countries and the impact of policies that restrict access to healthcare; a systematic review and meta-analysis. Journal of Migration and Health, p.100391. https://doi.org/10.1016/j.jmh.2025.100391

Annotation:

This systematic review and meta-analysis examines maternal and early childhood health and social outcomes for migrant women and families in high-income countries, with particular attention to the effects of policies that restrict access to healthcare. It reports associations between restrictive policies such as charging, eligibility limits, and administrative barriers and poorer health outcomes, delayed access to care, and adverse social impacts. The review highlights that policy environments shape not only service access but also trust, engagement, and longer-term wellbeing for women/birthing people and children. Its relevance to the

Collective's discussions lie in demonstrating that inequities in maternity and early years outcomes are influenced by political and policy decisions beyond the clinical setting. The findings underscore that exclusionary healthcare policies may contribute to preventable harm and reinforce existing inequalities, with implications for equity, public health, and system accountability.

Sands and Tommy's Joint Policy Unit (2025) Not Just an Option: Interpreting asan Essential Component of Safe Maternity and Neonatal Care. London: Sands and Tommy's.

Annotation:

This report reframes interpreting from a discretionary service to safety-critical infrastructure in maternity and neonatal care. Drawing on bereavement, safeguarding, and consent contexts, it shows how a lack of professional interpretation contributes directly to harm, exclusion, and trauma, reinforcing the need for interpreting to be embedded as standard practice rather than an optional adjustment.

Workforce, staffing, retention, and wellbeing

Birthrate Plus (2026) *Enabling Safe, Effective Staffing: An Independent Review of the Birthrate Plus Methodology*. Birthrate Plus. Available at: https://birthrateplus.co.uk/wp-content/uploads/2026/01/Birthrate-Plus-Methodology-Review-REPORT.pdf (Accessed: 09/02/2026).

Annotation:

The Birthrate Plus Methodology Review (2026) presents the outcome of an independent, evidence-informed review of the Birthrate Plus workforce planning methodology, which has been widely used across UK maternity services to assess midwifery staffing needs. The report details the principles, data inputs and consensus processes underpinning the method, situating it within contemporary maternity workforce planning and outlining how it models clinical need, acuity and service demand to generate staffing recommendations that align with current clinical standards and practice expectations. Drawing on extensive consultation with maternity stakeholders and comparison with existing workforce planning tools, the review also examines key methodological assumptions and identifies areas for refinement. This document informed the Collective's thinking about safe staffing by deepening its understanding of how established workforce planning tools operationalise clinical need into staffing ratios and by highlighting both strengths and limitations of current methodologies. This review supported the Collective's emphasis on the need for staffing approaches that are transparent, evidence-based

and capable of reflecting the full scope of clinical practice.

Care Quality Commission (CQC) (2024) Maternity services national review: staffing findings. London: CQC.

Annotation:

The CQC identifies staffing shortages and instability as core safety risks. The implication is direct: services cannot deliver safe or compassionate care when working conditions themselves are unsafe.

Feeley, C. and Stacey, T. (2024) 'Novel solutions to the midwifery retention crisis in England: an organisational case study of midwives' intentions to leave the profession and the role of retention midwives', Midwifery, 138, 104152. doi:10.1016/j.midw.2024.104152.

Annotation:

Further expanding on the known midwifery workforce crisis, these researchers carried out an organisational case study within one Trust to explore the whole midwifery teams' intentions to leave; either the Trust as a workplace or leave the midwifery profession. With a 74% response rate from the midwifery staff, they found that there was a clear link between midwives' intention to leave or stay and their workplace roles. For example, specialist midwives (e.g., perinatal mental health lead midwives and similar) were more likely to stay, report satisfaction, autonomy, and feel a sense of contribution or effectiveness mirroring the elements of the ABC model (see West). Conversely, ward-based hospital midwives were more likely to want to leave and report lower rates of autonomy, belonging or contribution and revealed much higher rates of stress. Other issues were identified such as the 'eroding role of midwifery' where administrative IT tasks limited their ability to care and reduced their job satisfaction. However, the protected role of 'retention midwives' funded by NHSE at the time of the study were found to be making a positive difference to midwives' experience of the workplace. This study highlights the extensive activities they carried out to support the midwives and should be emulated elsewhere.

Griffiths, P., Turner, L., Lown, J. and Sanders, J. (2024) 'Evidence on the use of Birthrate Plus® to guide safe staffing in maternity services: a systematic scoping review', Women and Birth, 37(2), pp. 317–324. doi:10.1016/j.wombi.2023.10.004.

Annotation:

This paper examines how Birthrate Plus is used in practice, supporting transparent

workforce assessment while warning against its misuse as a mechanism for constraining staffing rather than ensuring safety.

Hunter, B., Fenwick, J., Sidebotham, M. and Henley, J. (2019) 'Midwives in the United Kingdom: levels of burnout, depression, anxiety and stress and associated predictors', Midwifery, 79, 102526. doi:10.1016/j.midw.2019.08.010.

Annotation:

Building on research from the 1990s as to why midwives leave, this UK-wide research explored the workplace conditions of midwives within contemporary settings. The study found that the UKs midwifery workforce was experiencing significant levels of emotional distress. 83% (n = 1464) of participants scored moderate and above for personal burnout and 67% (n = 1167) recorded moderate and above for work-related burnout. Client-related burnout was low at 15.5% (n = 268). Over one third of participants scored in the moderate/severe/extreme range for stress (36.7%), anxiety (38%) and depression (33%). Personal and work-related burnout scores, and stress, anxiety and depression scores were well above results from other countries in which the WHELM study has been conducted to date. Midwives were more likely to record high levels of burnout, depression, anxiety and stress if they were aged 40 and below; reported having a disability; had less than 10 years' experience; worked in a clinical midwifery setting, particularly if they worked in rotation in hospital and in integrated hospital/community settings.

West, M. and Coia, D. (2019) Caring for doctors, caring for patients. London: General Medical Council.

AND

West, M., Bailey, S. and Williams, E. (2020) The courage of compassion: Supporting nurses and midwives to deliver high-quality care. London: The King's Fund.

Annotation:

These two large pieces of work were led by Professor Michael West, a compassionate leadership expert. Both pieces of work were designed to explore what doctors (report 1) and what midwives (and nurses) needed to provide excellent compassionate care (report 2). Both reports interviewed these NHS professionals to determine what they needed to not only do their job, but to thrive within their job. The 'ABC' framework (autonomy, belonging and contribution) situates their needs, clearly articulating what organisations need to enable staff to care for patients. It provides a model for conditions for better patient/client care.

Kline, R. and Warmington, J. (2024) Too hot to handle? Why concerns about racism are not heard… or acted on. Birmingham: brap. Available at: https://www.brap.org.uk/post/toohottohandle (Accessed: 13/01/2026).

Annotation:

This report documents how fear of retaliation, inaction, or reputational harm prevents staff from raising concerns. Read alongside WRES data and RCN evidence on racism, it helped the Collective to understand why unsafe cultures persist and why marginalised staff are disproportionately silenced, undermining both workforce wellbeing and patient safety.

NHS England (2024) Workforce Race Equality Standard data report. London: NHS England.

Annotation:

This report presents national data on racial disparities in NHS staff experience, including discrimination, bullying, and career progression. It shows that Black and brown staff experience poorer workplace conditions and lower psychological safety. The Collective used this data to link workforce inequity with safety culture and the ability of staff to raise concerns about unsafe care.

Royal College of Nursing (RCN) (2025) RCN reports rise in members facing racist abuse. London: Royal College of Nursing.

Annotation:

This report documents a reported increase in racist abuse experienced by nursing staff in the UK. It highlights how racism within healthcare workplaces affects staff wellbeing, retention, and willingness to speak up. The Collective used this evidence to support discussions and analysis of how workforce racism can undermine both staff safety and patient care.

Queensland Nurses and Midwives' Union (2023) *Unsafe: Qld midwives allocated up to 20 mothers & babies*, 3 August. Available at: https://www.qnmu.org.au/Web/Media_and_Publications/Media_Releases/Media_release_uploads/2023/Unsafe_Qld_midwives_allocated_up_to_20_030823 (Accessed: 04/02/2026).

Annotation:

This media release from the Queensland Nurses and Midwives' Union (QNMU) reports on findings from the "Count the Babies" audit, which revealed that midwives

in Queensland maternity services were at times responsible for the concurrent care of up to 20 mothers and newborns. The source highlights how staffing calculations often fail to adequately account for the care needs of both mothers and babies, resulting in unsafe workloads and increased risks to the quality and safety of care. This evidence informed the Collective's discussion on safe staffing ratios in UK maternity and neonatal services, particularly the recommendation that both mothers and babies be explicitly included within ratio calculations. By demonstrating how newborn care is frequently rendered invisible in workforce planning, the source reinforced the need for staffing ratios that accurately reflect the full scope and complexity of midwifery care.

Clinical negligence, financial impact, and system learning

National Audit Office (NAO) (2018) Managing the costs of clinical negligence in trusts. London: National Audit Office.

Annotation:

The NAO links rising negligence liabilities to unresolved safety issues across the NHS. Its findings support the case that investment in prevention and governance is a necessity for sustainability, not a discretionary cost.

NHS Resolution (2022) Five years of cerebral palsy claims: A thematic review of NHS maternity litigation. London: NHS Resolution.

Annotation:

This review traces high-value claims back to recurring system failures, including communication breakdowns, missed escalation, and staffing pressures. It reinforces the argument that harm arises from conditions of care, not isolated mistakes.

NHS Resolution (2025) NHS Resolution annual report and accounts 2024/25. London: NHS Resolution.

Annotation:

This report identifies maternity as a national priority area for risk reduction. It shows that maternity accounts for a small proportion of claims by number but the majority by value, reflecting the lifelong impact of severe, preventable harm. These figures now sit at the centre of NHS risk and finance discussions.

Governance, ethics, and standards of public life

Adams, M.A., Bevan, C., Booker, M., Hartley, J., Heazell, A.E.P., Montgomery,
National Maternity and Neonatal Collective: *Prioritising safe, equitable, compassionate, human-rights centred care for all service users and staff; centring the needs of Black and brown women and birthing people, along with those from other marginalised communities.*

E.,Sanford, N., Treadwell, M. and Sandall, J. (2024) Strengthening open disclosure in maternity services in the English NHS: the DISCERN realist evaluation study. Health and Social Care Delivery Research. doi:10.3310/YTDF8015.

Annotation:

This realist evaluation examines how open disclosure operates in maternity services following adverse events, and identifies the organisational, cultural, and relational factors that influence whether disclosure is experienced as meaningful or performative. The study highlights how fear, blame, hierarchical cultures, and inconsistent leadership may inhibit openness, while psychological safety, clear governance, skilled support for staff, and visible organisational commitment can enable more honest and compassionate responses to harm. Within the Collective's thinking that open disclosure is not simply a matter of individual professionalism, but also dependent on system-level conditions, accountability structures, and ethical leadership. The study supports the Collective's emphasis on transparency, duty of candour, and governance arrangements that prioritise learning, trust, and justice.

Committee on Standards in Public Life (1995) First report of the Committee on Standards in Public Life. London: HMSO.

Annotation:

This report established the Nolan Principles of Public Life, setting expectations for accountability, openness, honesty, and leadership in public institutions. These principles provide a clear ethical lens through which failures in maternity governance and crisis response can be assessed.

Closing note

Taken together, these sources were discussed by the Collective alongside lived, professional, and clinical experience and were understood to show that harm in maternity care is patterned rather than exceptional, and that risks relating to equity, safety, governance and accountability have been repeatedly identified across disciplines and sectors.

While many sources address harm and system failure, others describe practices, models of care, and system features that have been associated with safer and more equitable maternity care in particular contexts. It was on this basis that the Collective identified its priorities and solutions.