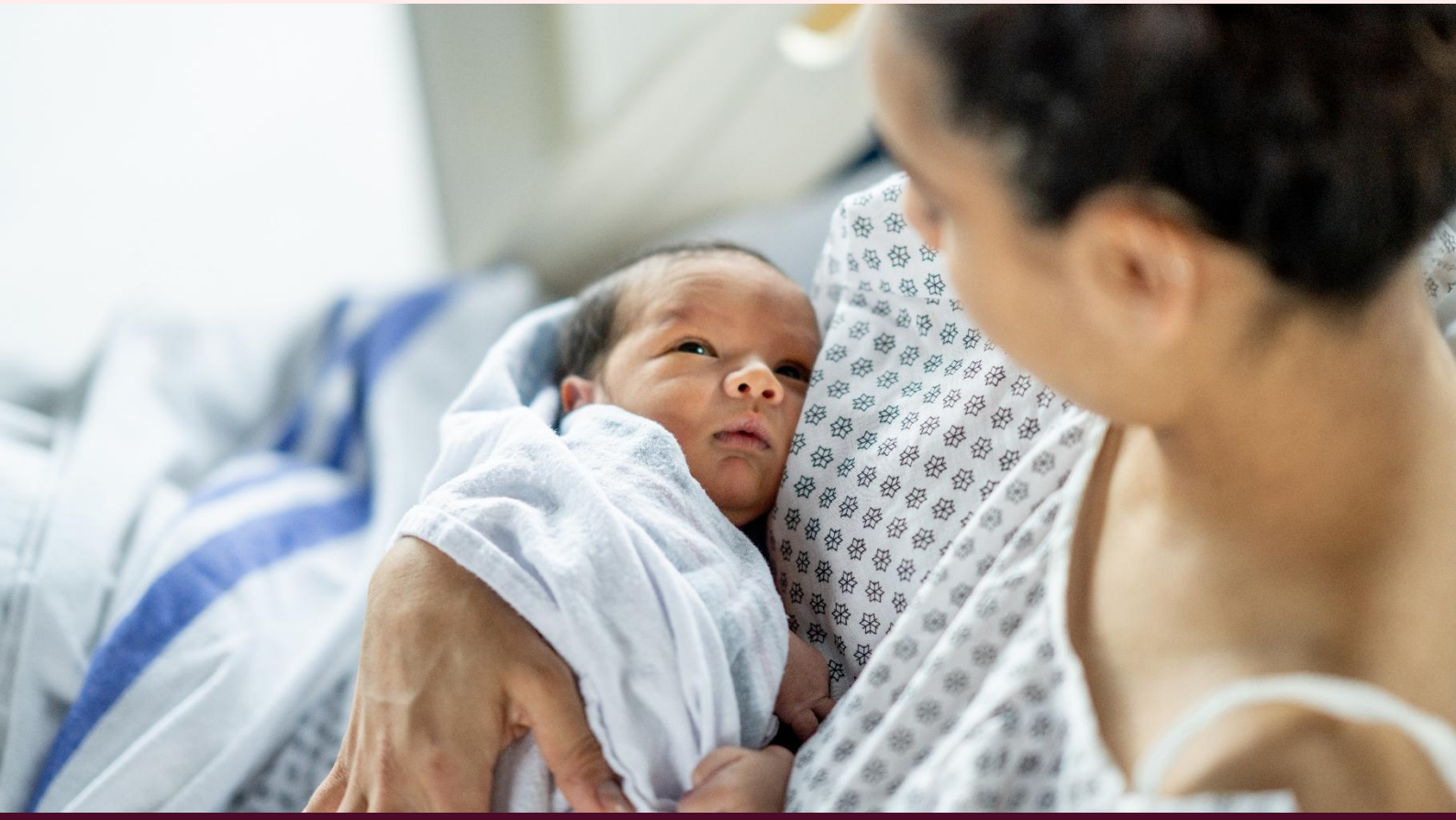
14 July 2026

Shared Insights

Maternity safety in focus

Speakers

Amelia Newbold – Risk Management Lead, Browne Jacobson
Sarah Land – Co-Founder and CEO of the charity Peeps
Dr Denise Chaffer – CBE FRCN
Ms Jyoti Sidhu – Consultant Obstetrician and Gynaecologist, Royal Berkshire NHS Foundation Trust
Lorraine Cardill – Director of Midwifery and Neonatal Services at George Eliot Hospital NHS Trust and South Warwickshire University NHS Foundation Trust



Browne Jacobson

Introduction

The National Maternity and Neonatal Investigation represents one of the most significant moments in the history of maternity safety in this country.

Its recommendations, published on 30 June, are far-reaching. They touch on how we listen to women and families, how we investigate when things go wrong, how we lead organisations, how we educate and support our workforce, and how we address the deep inequalities that continue to affect outcomes and experiences.

In this special extended edition, we heard legal, patient and clinician perspectives and discussed a range of issues including the importance of:

- Listening to patients and facilitating family engagement at the right time and in the right way.
- Shared decision making and informed consent.
- Antenatal education.
- Effective use of the Patient Safety Incident Response Framework (PSIRF) and staff experiences.
- A Just and Learning culture.
- Systemic implementation of recommendations and prioritising actions in the context of recommendation overwhelm,
- Effective leadership, board accountability and rebuilding trust in the system.

The session was chaired by Browne Jacobson's Kelly Buckley.

Contents

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Key findings and recommendations

Amelia Newbold –
Risk Management Lead at Browne Jacobson

Amelia discussed the key findings and recommendations from the final report of the National Maternity and Neonatal Investigation, (NMNI) which was published on 30 June 2026, and the subsequent 10-point action plan that NHS England set out for trusts in response.

The NMNI is national in scope with a whole system view - looking at people, culture, organisation, processes, infrastructure and the wider factors impacting on the care delivered by maternity and neonatal services. Many of the systemic issues and findings are not new and whilst previous independent investigations have looked at maternity and neonatal care in individual trusts, similar themes have previously been identified. A key question now is what can be done differently to ensure the change that is needed, and, as part of this, how can organisations and staff be supported to deliver these changes in a sustainable way. While there is much work to do across the NHS, this is also an opportunity to reflect on the progress already being made and strengthen collaboration. It is important to recognise the commitment and dedication shown every day by maternity and neonatal staff and there is an opportunity to learn from good practice alongside the learning from what has gone wrong.

Key findings and recommendations

The findings highlight that maternity, and neonatal care failures are systemic rather than isolated issues with themes including poor listening to women and families, embedded racism and discrimination, inconsistent safety standards, staff burnout, and fragmented care delivery.

The NMNI makes eight recommendations seeking to ensure high-quality, compassionate, and equitable care. These can be summarised as follows:

1. The creation of a National Maternity and Neonatal Commissioner with statutory powers to oversee a national plan to reduce variation in care and ensure accountability.
2. Listening to women, birthing people, and families must be treated as a safety-critical function, not an afterthought. Trauma-informed practice and psychological support must become standard after harm and services must embed mechanisms to hear and act on patient experiences, ensuring that women's voices influence care decisions and policy development .
3. Improved response and learning from incidents - the system should enhance how it responds to adverse events, learns from mistakes, and implements changes to prevent avoidable harm, with provision for families to have the right to request an independent investigation, should they remain dissatisfied after a Trust's internal investigation process,
4. The report also calls for the development of a Modern Service Framework to establish national standards for maternity and neonatal care to consistently achieve high-quality outcomes and safety across all Trusts. Within this, maternity triage must be formally designated as a safety-critical clinical environment, with binding national standards rather than guidance.
5. Racism, discrimination, and inequality are key themes with recommendations designed to address structural inequalities and ensure anti-racist practices are embedded at every level, improving equity in care and staff wellbeing. Racism and poor behaviour must be treated as patient safety issues — not HR issues — with clear accountability at board and regulatory level.
6. There is a need to strengthen governance, accountability, and regulatory oversight to ensure consistent implementation of standards.

7. Culture, teamworking, and leadership are also key areas with the need to promote a culture of compassion, collaboration, and strong leadership across all professional groups to reduce burnout and improve patient care
8. Recommendations that seek to modernise estates and digital systems to support safe, efficient, and patient-centred maternity and neonatal care

The report also addresses potential changes to the coronial system, the compensation and litigation framework, freebirth guidance, and regulatory reform.

What needs to happen now

Summary of NHS England's 10-point plan

1. The roll out of Martha's Rule across all maternity and neonatal services.
2. Boards must adopt a monthly cycle of collecting and publishing real-time patient outcomes and experience data.
3. A requirement for Trusts to establish joint Medical Director and Chief Nurse accountability for maternity and neonatal services, with shared oversight across obstetric, midwifery, neonatal, and operational leadership.
4. An 'Amos into action' staff listening exercise – with NHS staff and leaders to identify how the recommendations can be implemented across the system.
5. Action to tackle inequalities now including confirmation that the Perinatal Equity and Anti-Discrimination Programme must be rolled out to all trusts by the end of 2026, with the Maternal Care Bundle implemented by March 2027 and regular board review of inequality dashboards.
6. A requirement for every Trust must complete a board-level triage audit within three months, implement dedicated midwifery staffing separate from the labour ward, ensure 24/7 capacity and escalation routes, and deliver improvements within 12 months.
7. Strengthening of the requirement for Trusts are to review their homebirth services.
8. Actions to facilitate improvements in responding to patient safety incidents, complaints and concerns with a focus on humanity, candour and a trauma-informed approach.
9. All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced.
10. All trusts must implement actions set out in the system letter following the Fuller and NUH reviews and every board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve.

The message from Baroness Amos is clear: safety must be redesigned into the system — through listening to women, dismantling structural racism, and building services that learn in real time, not only after harm has occurred.

The 10-point plan provides the immediate lever. The Taskforce's National Action Plan in December 2026 will be the moment to drive this at pace and at scale. But of course, the test is not in the planning — it is in the doing. This session provided useful insights into how to achieve meaningful and sustainable system change through the provision of a supportive, psychologically safe working environment for staff to rebuild trust and improve outcomes for women, birthing people and families.

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Sarah's experiences and perspectives

Sarah Land –
Co-Founder and CEO of the charity Peeps

Sarah shared her own experience following delivery of her daughter, Heidi, the emotions felt during their difficult time and wanting to make a difference for future and support other families.

Sarah reflected that she had a very straightforward pregnancy and was classed as 'low risk'. However, unfortunately, Heidi had a sudden post-natal collapse and that is when their lives changed. They watched Heidi being resuscitated and taken away from them and Sarah described feeling at that time like they were the only people in the world that this had happened too. They were not listened to when Heidi was taken away for cooling and Sarah and her partner experienced a range of emotions during that difficult time from anger, upset, pain before reaching a point of acceptance and wanting to try and make a difference for future families so that no one else goes through the same thing.

Sarah shared that at the time of Heidi's collapse they were told that it was 'just one of those things' and they were provided with a leaflet which had been put together by the Trust to go to new parents. Sarah says this reinforced her belief that she had done something wrong. In the absence of having answers, families will blame themselves.

What we remember as parents

Whilst there are many difficult memories for Sarah, she also looked back and has positive feelings. Sarah said there were times when she knew they were being so well looked after, being listened too and being cared for with compassion. For example, there was a cleaner who came in every morning (they were in hospital for eight weeks in total with Heidi) and she always asked how Sarah was, instead of the focus being purely on Heidi. When they left the hospital, she wrote on a message on a paper towel wishing them all well. Her kindness is still with them 11 years on. People who listened meant a lot to them.

The provision of clear information and explanations is also very important. Sarah recalled one of the very early discussions with a consultant who said Heidi was going to be 'cooled' without explaining what that meant. Families know how busy staff are but communication with families at such a difficult time is so important. There is also a need to acknowledge the fear that may be experienced by families - it is not about staff saying they can fix things but about hearing and listening to families.

What is key for families, which has come though from the various recent maternity reports and previous reports, is the need for family centred care with clear, sensitive communication, recognising that all families are going to be different as to when they want information. Sarah advised asking families about this to avoid any risk of re-trauma in the early days. Be sensitive to families having to re-tell what has happened multiple times and provide appropriate support and signposting to try and prevent families from turning to Google which can be terrifying. Ensure the adoption of inclusive practices - asking families what matters for them at that point; when they want to receive information and how much information they want. Each family will feel differently about this.

The impact on families' lives is far reaching with financial and relationship impact, mental health challenges, having to learn medical things and this is not 'life as planned'. Legal process add further layers of complexity. Be mindful as to what is going on for them re milestones and anniversaries. Building trust. Sarah referred to Brené Brown's anatomy of trust and the idea of marbles in a jar i.e. that trust builds slowly, *"a marble at a time".*

When a family has a birth injury, there is impact beyond the neonatal period, it has financial and relationship impacts, mental health challenges, families are having to learn medical terminology, and this is not life as planned. If there is a legal process this adds further layers of complexity.

Sarah explained that people should be mindful as to what is going on for the family and made examples such as milestones and anniversaries and being mindful around appropriate communication at that time.

The sheer scale of the reviews and media coverage currently makes it very difficult for all involved.

As part of Sarah's work with Peeps, one thing that is clear from the recent maternity and neonatal investigations is that there are no surprises about the findings and conclusions. It is now about seeing change rather than further investigations.

Sarah concluded her discussion with three takeaways:

- Listen, do even move listening than you are currently doing and ask what will help or what will make a difference.
- Offer choices. Different choices will be made by different families.
- Show you are human; no one expects you to have all the answers.

Further reading: Sarah Land – Heidi, me and HIE (Peeps)

Contact details for Peeps for anyone who has been affected by a HIE event (including healthcare professionals, families, staff) can contact Peeps for support and their details can be found below.

https://www.peeps-hie.org/

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0800 987 5422
07838 197 945

Jyoti's experiences and perspectives

Ms Jyoti Sidhu – Consultant Obstetrician and Gynaecologist at Royal Berkshire NHS Foundation Trust

Jyoti shared her experience from working on the frontline.

Jyoti shared a graph on page 8 from the National Perinatal Epidemiology Unit (NPEU) which shows caesarean section rates across Europe and the USA. The USA rates have stayed static, as have most other countries. The statistics for England have an accelerating trajectory and whilst there is an increase maternal age, obesity and other risk factors these risks apply to other countries which have not seen the same rises. Jeremy Hunt introduced England's National Maternity Safety Ambition in 2015 with the aim to reduce rates of stillbirth, neonatal and maternal deaths by 50% by 2030. The graph shows that the rates of stillbirth, neonatal and maternal deaths are falling but only by about 20%, not as much as we would have hoped.

Neonatal brain injuries have reduced, and maternal mortality rates have risen.

This data helps us to understand where we are.

Culture

We must think about culture, but it is nebulous and difficult. The work of Sidney Dekker, Restorative Just Culture raises three questions following an incident:

- Who is hurt? (usually involves staff, families)
- What do they need?
- And whose responsibility is it to meet that need?

Mr Dekker found by and large, speaking to families, staff and patients, they all need the same things. They need wellbeing and support. At present, Trusts are not very good at keeping families up to date and equally, are not good at keeping the staff involved or updated either.

So, what do we do with that?

Empowering women

Consideration needs to be given to antenatal education, knowledge is power. If we get this right, it will help informed decision making, consent and hopefully reduce the very high levels of birth trauma which has a knock-on effect for subsequent requests for care 'outside of guidance'.

Staff education

Antenatal education needs to take place alongside effective staff education. There is a lot of mandatory training for staff, and we have excellent educators and a nice framework etc. but it does not always work. An example of this is with PROMPT, We are still not delivering the change that the late Professor Tim Draycott did when he implemented PROMPT in Bristol. We need to think about doing things differently, rather than pursuing the same delivery of the same training where it is not working. For example. could we think about tailoring training and education to specific areas of work - training a small number of staff in each area and empowering them to go and teach other staff in those areas to help embed learning – the see one, do one, teach one analogy. It is about reviewing what has already been done, understand what has worked and then being honest about what is not working and trying something different.

PSIRF

Due to the complexities in maternity, PSIRF is difficult to implement effectively. However, PSIRF provides an opportunity to make a real difference through system level and real tasks. Tasks relate to the actions that must be done when an incident has happened, e.g. share learning, reflections, share reports with families etc. These tasks all need to be done but they do not prevent the same thing happening again. In contrast, system actions make it easier for staff to do the right things at the right time or stop staff doing something in the wrong way at the wrong time, for example, the use of specific connectors in epidural catheters; and having the right IT systems in place. We need to be applying PSIRF principles to the national landscape as well as the local landscape. We know what the issues are and need to focus resource more on finding solutions rather than continuing to investigate the same issues..

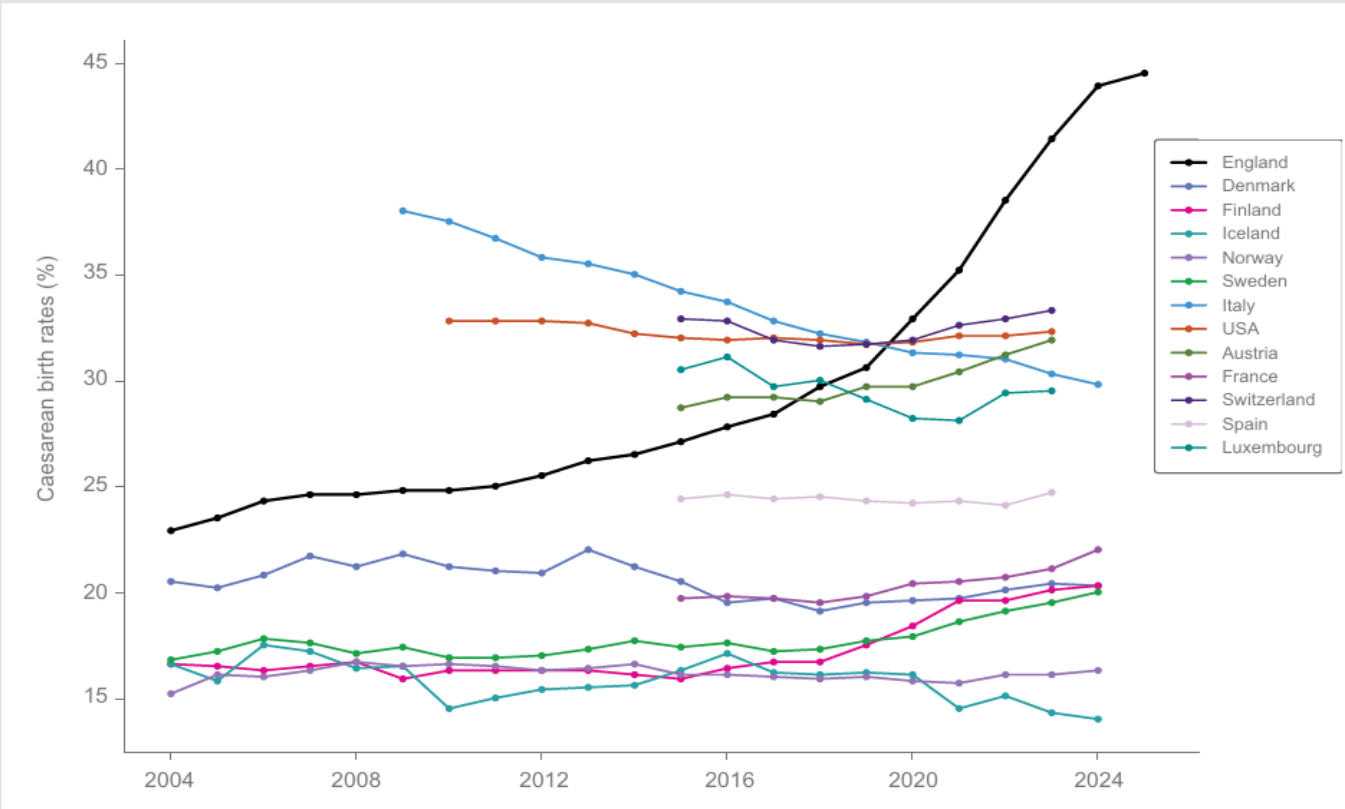
So how do we solve the problem?

Jyoti highlighted the need to prioritise action e.g. focus on triage, a difficult high-risk setting. Complexity has increased and footfall has at least doubled locally over the last two years, for a variety of reasons. It is important to identify areas for priority and a need to develop specialists who are knowledgeable, skilled and passionate in those areas - we need staff who really believe that change is possible.

Key takeaways

Learn from the past, the good and the bad, and find constructive ways to move forwards, prioritising key areas of focus and empowering women and staff..

Figure 1: Trends in Caesarean births in England, western Europe and the USA, 2004-2025



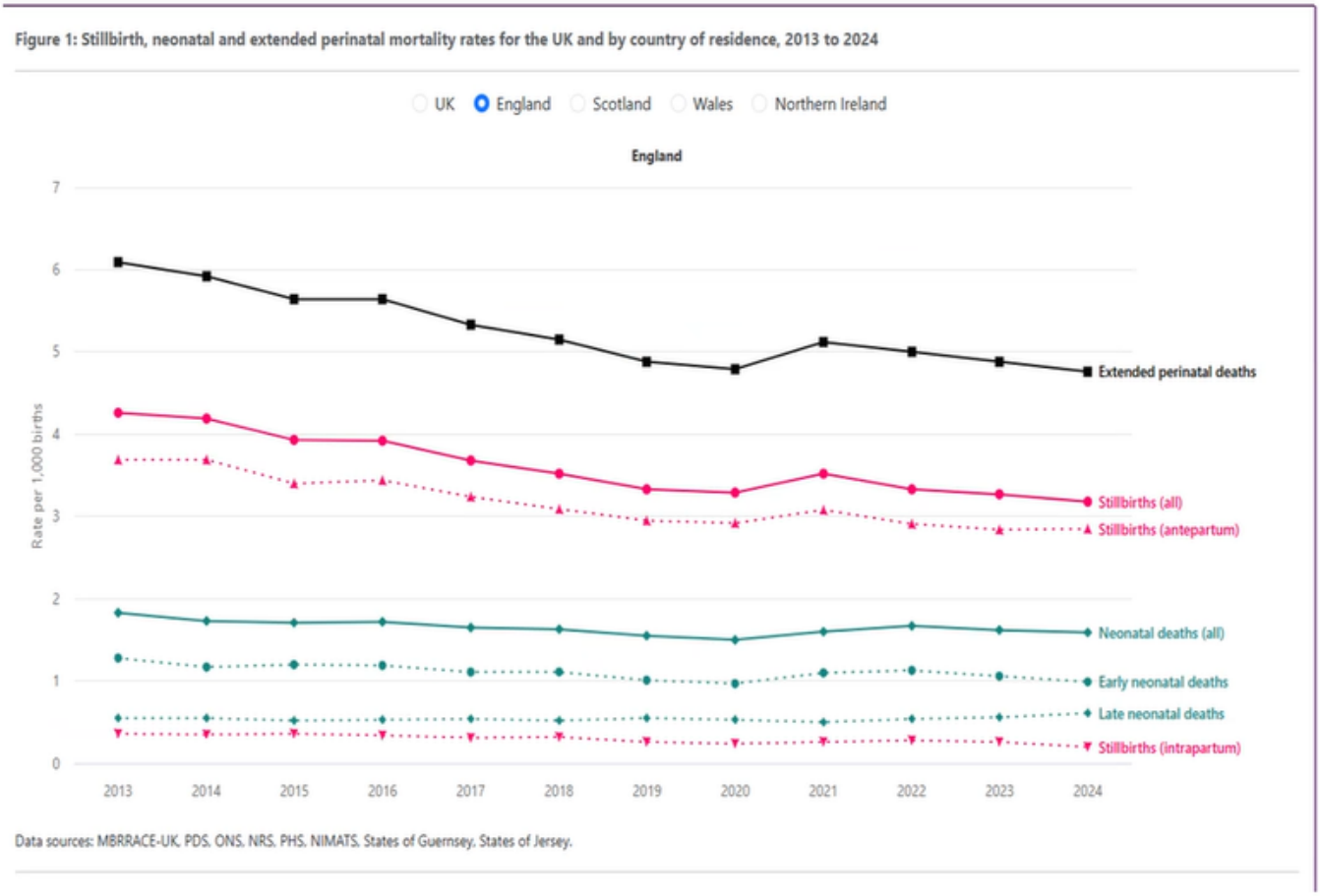
Chart

Achievements against 2025 maternity safety ambitions

18/02/2026

Metric	Target for 2025	Data in 2010	Latest data
Maternal mortality rate per 100,000 births in the UK (MBRRACE-UK)	5.31	10.63	12.8 (2022-24) Not on target
Stillbirth rate per 1,000 births in England (ONS)	2.6	5.1	3.8 (Jan-Sep 2025 provisional data) Not on target
Neonatal mortality rate per 1,000 live births of infants born at 24 weeks or over in England (ONS)	1.0	2.0	1.4 (2023) Not on target
Preterm births percent born before 37 weeks of gestation in England (ONS)	6%	8%	7.9% (2022) Not on target
Neonatal brain injury all gestational ages, per 1,000 live births in England (Imperial)	2.13	4.25	4.18 (2021) Not on target

The national maternity safety ambition aimed to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030.



Lorraine's experiences and perspectives

Lorraine Cardill – Director of Midwifery and Neonatal Services at George Eliot Hospital NHS Trust and South Warwickshire University NHS Foundation Trust

Lorraine shared her experience about being a leader on the frontline. Front line teams are committed to implement change; but improvement must be achieved on a sustainable level.

Fear

The overwhelming feedback from women following the recent maternity and neonatal investigations is fear and a loss of confidence in the services.

Staff are also fearful of blame, litigation and feel defensive in their practice. In most cases care is being delivered well, and we need to think about how we support staff in the work they are doing.

Trust boards are also now very anxious because of the investigations and are fearful of the impact on their services; they are also looking for assurance.

Overwhelmed as leaders

In the last 6 months a lot of new guidance and recommendations have been published, including the home birth review, launch of Maternal Outcome Signal System (MOSS), the Perinatal Equity and Anti-Discrimination Programme, Ockenden review, Amos report, the NHS England 10-point plan etc., as well as ongoing requirements for Saving Babies Lives, This is on top of everything else on the day-to-day 'to do' list. In the context of so many recommendations, it is important to have a programme that staff can realistically deliver.

As leaders, we need to be inspiring change, maintaining safe staffing as well as achieving cost saving programmes. With every recommendation, women and birthing people must be at the heart of everything we do. Making sure we have workforce capacity to do that.

Leaders need time to consider how to implement the recommendations, working together collaboratively. Organisations need governance support and financial assistance. Boards need to be sighted on all culture concerns.

The need to be brave as leaders

Not everything that is recommended will 'fit' every unit. Practice is different in every unit and a 'one size fits all' approach won't work.

So, we need to ask is it a recommendation or a 'must do' and is it deliverable? Is it evidence based? Do we have sufficient resource and how do we measure success? Is it simply a process change and could it create unintended consequences? What does good actually look like and how do we get there?

There are potential unintended consequences with the implementation of new recommendations such as increased admin, staff burnout, less time with women etc. If we look to other sectors like aviation, they use a rigorous process and risk assessment when they need to make a safety change, so they can identify what is needed to control the risks.

It is so important we listen to patients and staff and when we make changes. We need to remain focused on outcomes and not compliance. Utilise resources from within the whole organisation, not just maternity alone.

The challenge is creating conditions where change can flourish, and Lorraine stressed the importance of not changing things for change's sake.

Lorraine concluded with three ket takeaways:

1. Prioritise wisely.
2. Listen relentlessly.
3. Stay connected as leader.

Denise's experiences and perspectives

Dr Denise Chaffer – CBE FRCN

Denise posed the question, are we doing all we can to learn from and prevent harm, and are we doing all we can to improve the way we respond to harm.

Denise shared her experiences following her involvement as Chair of the Independent Review of maternity and neonatal services at Swansea Bay University Health Board.

Denise explained that when the report was published the Chair and CEO of the Health Board accepted the findings of the report in full acknowledged the harm that had been caused, apologised unreservedly and committed to act, using restorative justice principles. This was important in helping with families healing alongside learning - see O'Hara, J. K., & Murray, M. (2022). Humanizing harm: Using a restorative approach to heal and learn from adverse events. *Journal of Patient Safety and Risk Management*, *27*(2), 65–71. doi.org.

Following publication of the report in July 2025, Swansea Bay University Health Board also commissioned the independent review's oversight panel to continue to work with the board support implementation of the recommendations and support sustainable change. This included agreeing key themes and identifying key priorities, namely:

1. **Safety critical factors** – issues around triage, induction of labour, rising caesarean section rate, two-site working and the requirement to implement Maternity Early Warning Scores.
3. **Community voices** – Focusing on improving both experience and involvement of women, families and experience. Many wanted work with the service and provide feedback to support improvement.
4. **Workforce and education, compassion and supervision for junior workforce.**
5. **Governance process and reporting to board, what should a Board have sight of and are families being supported with investigations.**

These are similar themes as found in the NMNI.

Once the themes had been identified, the oversight panel supported the health board to examine these in depth and worked to prioritise actions and change using quality improvement modelling; which included how to measure change; and focussing on a small of meaningful metrics to track progress and ensure sustainability of improvement.

It is also worth reflecting on the fact that whilst most families have a positive experience, there are around 4% that experience significant trauma requiring significant psychological support.

For some women it can be one encounter that has a significant impact One person's comment can let a whole service down, so it is important to be strong on expected behaviours.

A business case for change

There is a very powerful economic business case for change – harm costs a huge amount not just in terms of human cost but also in resources needed for investigations and, at times, legal costs. Prevention of harm must be a priority.

The need for dialogue and discussion

Currently there are a range of views about both the cause and how best to improve services and there is a real risk that we will lose the opportunity to have open dialogue and discussion if we don't encourage evidenced based conversations.

For example, in delivering training for midwives what do we know works both nationally and internationally and how does that impact on outcomes.

Denise also commented on triage. A new National Maternity Triage Specification was published on 7 July 2026, but it is important we think about what is needed and resources available to care for people safely and kindly.

In implementing recommendations, organisations need to be very careful that they really diagnose the problems, codesign solutions and don't move to quick actions to 'fix the problem and miss the point'.

Discussion and Q&A

Martha's rule – How do you think this will work in maternity?

Martha's Rule extended to all maternity services - GOV.UK

Jyoti confirmed that Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.

Some Trust's call this initiative 'call for concern' where the call goes through to the outreach nurses who triage them and respond. It has been a good service, and promising data is coming out of it.

In maternity, it is one of the ways we can help women and families to be heard. We always listen, but don't always hear what is said.

What do you think will be in place to ensure that any family requests for an independent investigation are assessed fairly/appropriately?

We will need to await more detail about this, but one idea might be to develop a resource, like an ombudsman to review local investigations if a family hasn't received satisfactory answers or haps concerns about the investigation process.

IT and processes can be blockers to system level change, but these blockers are felt by clinicians rather than the Board. How do you get around that?

When Denise started to work with staff as part of the Independent Review of maternity and neonatal services at Swansea Bay University Health Board, she noticed that whilst there were things staff had the power and authority to change, there were also some external factor blockers. The questions staff need to ask themselves are 'what am I empowered to do?' and 'What do I need somebody else to help me do?' One approach that helped was for the team to set up an Executive Programme Board.

A lot of the solutions are outside of and do not sit with maternity and neonatal services. Think about what you can change and what you need to get other people to support you to do. It's about highlighting risk.

Then it's a shared responsibility across an organisation, not just sitting with maternity.

What does a meaningful apology look like? How can that help rebuild the trust?

The panel reflected that they still see the use of non-apologies e.g. 'we are sorry you feel this way'. In addition, an apology at the end of a legal process (or even like Sarah's family, who were asked at the end of the legal process whether they would like an apology from the Trust) can feel disingenuous. Sarah commented that in her experience and when she speaks to other families, they are looking for a genuine and heartfelt apology, given at the time of the incident.

Denise reiterated that saying sorry is not an admission of liability and referred to the NHS Resolution guidance 'Saying Sorry'. An apology provides an opportunity to move defensiveness into evidence that a family has been heard and action for meaningful change.

How we can help

This session highlighted the importance listening to women, birthing people and their families and the role of education of patients and active listening to ensure informed consent.

Failing to obtain informed consent for treatment is a common issue we see in our claims work for NHS Trusts. In maternity services, that often relates to mode of delivery for example: failing to obtain informed consent for induction of labour, for Vaginal Birth After Caesarean (VBAC), instrumental delivery etc.

We are keen to support healthcare organisations in learning, and following a Trust request for support, we have developed some practical training to support all NHS Trusts and organisations around obtaining informed consent.

Our on-demand recorded training includes practical tips for clinicians to support patients with important decision making and obtaining informed consent. There is a clinician perspective from Dr Clare Tower, Consultant in Obstetrics and Maternal and Fetal Medicine with best practice examples. We cover what informed consent is in practical terms, why it is important (an overview of the legal framework), and learning from claims examples.

To further support Trusts, we provide a Legal toolkit (a practical checklist to support clinicians) FAQs, copy slides, and a maternity-specific supplemental document with best practice top tips.

The training aims to ensure improved personalised conversations with patients to ensure informed consent is obtained and with improved patient care and experiences which will hopefully reduce the risk of future complaints and claims.

If you would like more information about the training package, you can find it here

Alternatively, please contact: Rebecca Coe or Amelia Newbold.

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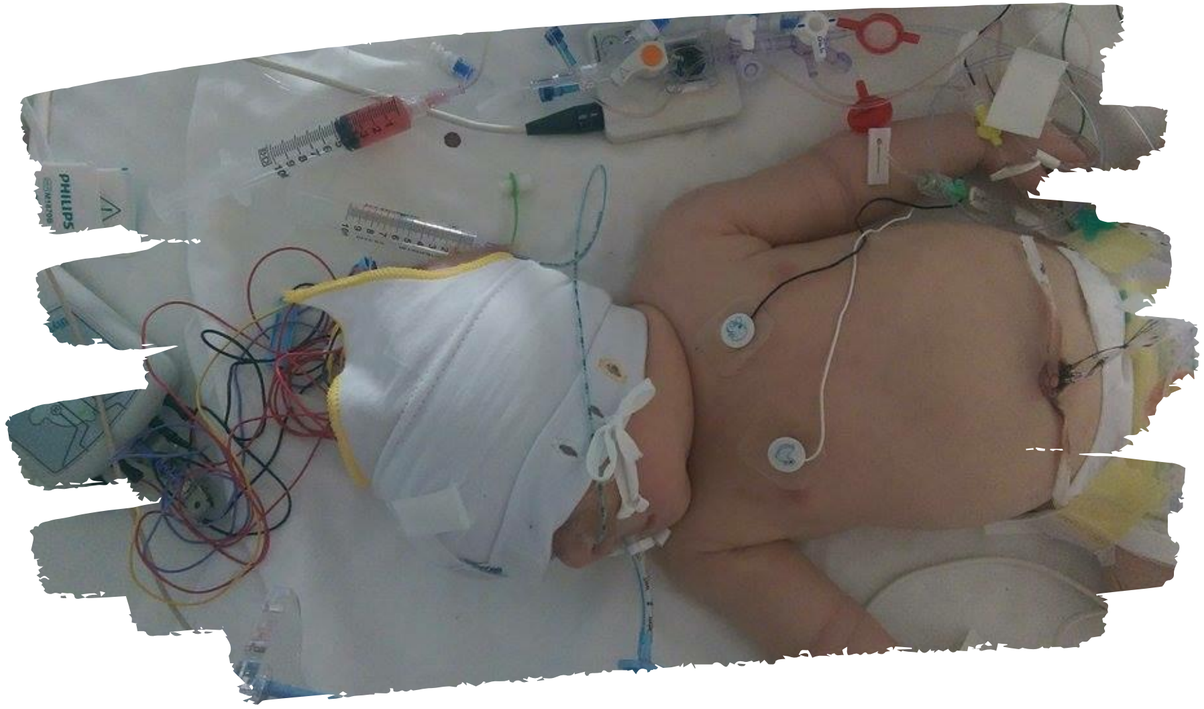
Heidi, me and HIE



24 hours apart...and a world of difference

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HIE AWARENESS & SUPPORT

What we remember

Who listened

Who explained

Who was kind

Who kept us informed

Who acknowledged fear

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What matters to families

Family centered care	• Including families in decision-making • Providing information – appropriate and accessible • Recognition of emotional and physical well-being of the family unit
Communication	• Open and honest communication (even, or especially, when things go wrong) • Clear, compassionate and culturally sensitive • No “one size fits all” solution
Trauma informed care	• Prioritizing the emotional and psychological safety of the family • A safe environment to voice concerns • Sensitive and compassionate care
Support	• Signposting to support at the earliest opportunity • Offering choices – reducing the need for families to search for help themselves
Inclusive practices	• Promoting equitable care for all • Addressing disparities in maternity care
Advocating for change	• Listening to the voices and needs of families • Working towards inclusive, equitable and safe care • Learning and ensuring safer care for future families

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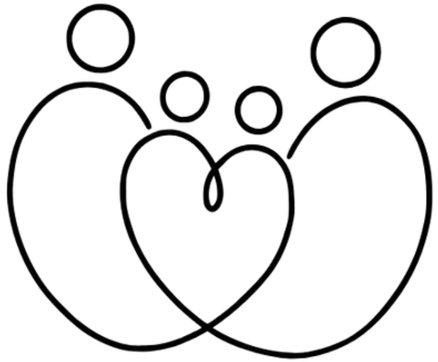
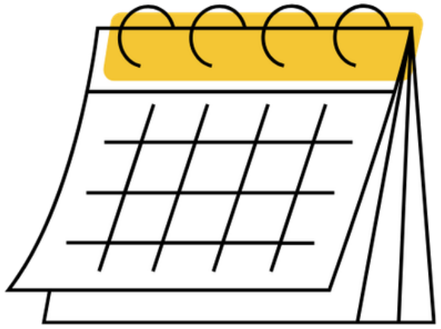
When things go wrong





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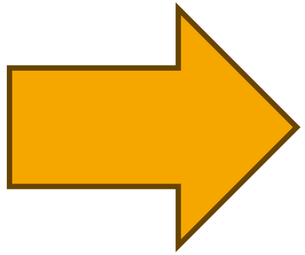
Building trust



The Anatomy of Trust, Brené Brown

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