Foreword

Every pregnant woman wants a positive birth experience – and every member of staff working in a maternity service wants to provide safe, high-quality care. In most situations that's what happens, but sadly, it's not always the case. For some families who are impacted by poor maternity care, the damage is irrevocable. No family should ever have to suffer in this way and everyone working in the health and care system has a responsibility to do all they can to prevent it happening.

Maternity services have been and continue to be under significant scrutiny. In recent years, several high-profile investigations have highlighted worryingly similar failings - a sobering reminder that efforts to improve have not yet done enough to address the underlying issues preventing safe, high-quality care being delivered every time.

In 2020 we shared our concerns about the variation in quality and safety of maternity services across the country in a briefing paper Getting safer faster: key areas for improvement in maternity services. Those concerns were further evidenced a year later in our thematic report on 'Safety, equity and engagement in maternity services', and more recently CQC State of Care reports have singled out maternity as a service that has seen a marked deterioration in ratings over time.

It was within this context that we introduced a targeted national maternity inspection programme. The programme aimed to provide an up-to-date assessment of maternity care across England – and to explore what lies behind the lack of progress in some services. It began in August 2022 and involved on-site assessments of all hospital maternity locations that had not been inspected and rated since before March 2021.

This report brings together the findings from inspections of 131 hospital maternity units carried out as part of that programme, setting out the key themes, evidence of good practice and the common areas of concern. It makes recommendations for NHS trusts, the wider system and national bodies.

Our programme of inspections has shown that there are hospitals providing good maternity care and we found some excellent practice. However, we also identified some common issues and concerns that too many women and babies are not always receiving the high-quality service they should expect.

Sadly, we found that the failings uncovered by Donna Ockenden and Dr Bill Kirkup following their reviews of maternity in individual trusts are not isolated. Many of the factors apparent at East Kent and Shrewsbury and Telford are more widespread. Key issues continue to impact quality and safety – and disappointingly, none of them are new. Poor management of incidents with limited learning when things go wrong, failure to ensure safe and timely assessment at triage, unsuitable estates and access to essential equipment, a lack of oversight from trust Boards and significant challenges in recruiting and retaining staff.

We know the inequalities in outcome and additional risks experienced by women from Black and ethnic groups are well documented, yet we found huge differences in the way trusts collect and use demographic data to try to address those disparities. Significant concerns also remain regarding the quality of communication with women and their families, and a failure to engage with and listen to their needs.

These findings are all too familiar - so why do they persist and what is stopping us from moving forward? We need to be more honest about the reality of the problem and recognise that we all have a role to play to ensure sustainable improvement. This starts with a robust focus on safety where the culture that prevails does not accept risks as the norm and where staff are supported to deliver the high-quality care they want to provide. The recommendations made in this report aim to help us achieve that goal and to ensure good safe care for mothers and babies of today and in the future.

This report sets out some hard-hitting findings. However, this should not detract either from the positive steps that have already been taken to support change or from recognition of the dedication and commitment of the maternity workforce. Our findings show that the work to help improve safety already underway needs to continue and that there are specific issues that must be tackled as part of NHS England's three-year delivery plan for maternity. The findings also underline why it's so important that we encourage staff and services to take learning from CQC inspections that identify good care. Alongside this report we have published a number of new online resources intended to do just that by sharing what is working well as a source of practical guidance and support.

Without action, the danger is that poor care and preventable harm will become normalised. We cannot and must not let that happen.

We would like to express our sincere thanks to all those who have contributed to this report, In particular, our thanks go to all the families who shared their experiences with us to help ensure safer, better care in the future.