Final report (learning resource)

22 March 2024

Evaluation of CQC’s national maternity inspection programme

The Healthcare Improvement Studies Institute

# Abstract

This report presents findings from an evaluation of the Care Quality Commission’s (CQC) national maternity inspection programme led by The Healthcare Improvement Studies Institute (THIS Institute) between May 2023 and February 2024. The study had two objectives: to characterise what good safety culture looks like; and to evaluate the programme and capture learning to inform future inspection.

This report focuses on the first objective. We aimed to characterise what good safety culture looks like in maternity services and the factors underpinning it. Using a range of methods, including literature review, workshops with maternity service users, and a consultative survey, a previous framework on the features of safe maternity units was matured into a practical learning resource to support improvement in maternity care.

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# Executive summary

## Background

Maternity services in England face significant challenges. In 2022, the Care Quality Commission (CQC) – the independent regulator of health and adult social care in England – began a new maternity inspection programme, covering all maternity services in England that it had not inspected or rated since April 2021. The programme focused on two of CQC’s five quality domains: ‘safe’ and ‘well-led’. CQC commissioned The Healthcare Improvement Studies Institute (THIS Institute) at the University of Cambridge, with RAND Europe, to undertake an evaluation of the maternity inspection programme. The evaluation had two objectives:

1. To characterise what good safety culture looks like in maternity services and the factors underpinning it;
2. To evaluate the national maternity inspection programme to maximise learning for maternity services, inspection, and the health and care sector more broadly.

This report provides an overview of key findings relating to the evaluation’s first objective. It presents a key output relating to this objective: a ‘learning resource’ intended to identify and describe the key features of ‘what good looks like’ in safe, high-quality maternity care. The learning resource aims to support stakeholders with an interest in maternity care – including not just inspectors, but also clinicians, managers, and maternity service users – in understanding where improvement efforts might be directed and what achieving good care would look like. It is not intended to form the basis of an inspection tool.

## Study design and methods

Conducted between May 2023 and February 2024, the study involved six workpackages in total, of which three were particularly relevant to the first objective and are reported here, labelled as workpackages A, B and C. A synthesis of learning from these workpackages then informed the final version of the learning resource. In brief, the workpackages and associated methods and data that related to the first objective were:

* Workpackage A: A **literature review of what good looks like for maternity safety culture**, using a framework-based synthesis of the existing academic and grey literature, and with a particular focus on equity, diversity and inclusion;
* Workpackage B: **Participatory workshops with maternity service users**, including 15 women from diverse backgrounds, which sought to obtain perspectives on the key features of high-quality maternity care, and on the developing learning resource;
* Workpackage C: A **consultation survey with maternity service stakeholders** including women, parents and birth partners, maternity service staff, CQC staff, senior leaders, managers and commissioners of maternity services, and people from campaigning and advocacy organisations, gaining further input into the developing learning resource; the survey was administered online and attracted 215 responses.

Fuller summaries of the methods used for each workpackage are provided in the chapters that follow, with full details provided in working papers that underpin the report.

## Literature review of what good looks like for maternity safety culture (workpackage A)

In this part of the study, we reviewed existing academic and grey literature on maternity safety culture, and on maternity service users’ outcomes and experiences of care, with a particular focus on equity, equality, diversity and inclusion of diverse groups and those from minoritised backgrounds. We brought insights from these literatures together to update an existing framework setting out the features of high-quality maternity units – the [‘For Us framework’](https://for-us-framework.carrd.co/). This existing framework provided an evidence-based starting point for this work, encapsulating key features of safe, high-quality care, that is already widely recognised in maternity services.

Our review found considerable gaps in knowledge relating to maternity service users’ experiences of maternity care, particularly in relation to the influence of ethnicity. Nevertheless, the available evidence does show that minoritised and socio-economically disadvantaged women are adversely affected by intersecting factors (including racism, language challenges, cultural differences, deficits in knowledge, sensitivity and competence in some health professionals, stereotyping and assumptions, and structural barriers) that result in worse outcomes and experiences across the different domains of quality. Insights from this literature offer many suggestions and recommendations for improving the quality of maternity care (see Chapter 3).

We used these findings to enrich and update the For Us framework, creating ‘version 2’ of the framework, which was used in later workpackages as a starting point for further development into a learning resource.

## Participatory workshops with maternity service users (workpackage B)

In this part of the study, we undertook a series of workshops (one in-person, two online) with maternity service users, with a particular view to ensuring that the emerging learning resource was informed by the views of women from a diverse range of backgrounds. Described in more detail in Chapter 4, the workshops sought to elicit views on the question of ‘what good looks like’ in maternity care, to articulate a vision of good maternity care, and to generate feedback on the extent to which the second version of the For Us framework did justice to these views, and thus offered an adequate basis for the learning resource.

Key insights from the workshops included the importance of a broad and inclusive definition of safety, encompassing not just immediate clinical safety but also other aspects (e.g. psychological wellbeing) and accounting for the mother and family as well as the infant. Many participants had found in their experience that choice and informed decision-making were not the norm, for example reporting that decisions had been made by staff about what was safe or appropriate regarding the mode of birth or that information was presented in a manner intended to direct them towards a particular option – and with limited opportunity to decline this option, even in an informed way. Making person-centred care a reality was therefore a key priority for participants.

Participants provided feedback on version 2 of the For Us framework that reflected these priorities. The framework as a whole had some face validity for participants, but they had specific comments on several of the individual features, and felt that more work was needed across the framework to do justice to the construction of safety that they had articulated. In particular, they argued that birth partners needed to be incorporated more explicitly, ensuring that their needs were considered alongside those of mothers.

Workshop participants commented particularly extensively on the features of the framework relating to respectful and inclusive behaviour and high-quality communication. They argued these could be strengthened to foreground the importance of *two-way* communication, with healthcare professionals listening attentively and responding to the preferences of maternity service users. They also highlighted the important ways in which staff behaviour can powerfully communicate what mattered, with implications for the respectfulness of interactions and for the realisation of genuinely person-centred care and maternal choice.

## Consultation survey with maternity service stakeholders (workpackage C)

In this part of the study, we designed and administered an online survey of maternity service users, staff and other stakeholders using the research, engagement and development platform [Thiscovery](http://www.thiscovery.org). As with the participatory workshops, we put version 2 of the For Us framework to survey respondents and sought their views on the extent to which it captured key features of high-quality, safe maternity care and culture, and thus provided an adequate basis for a learning resource.

Overall, respondents were very positive about the extent to which the features of the modified For Us framework represented ‘what good looks like’ for maternity service users and staff, with around 65% agreeing that it did so ‘to a great extent’ or ‘a very great extent’. Respondents also offered a range of recommendations for improving the framework further. Discussed in more detail in Chapter 5, these included an emphasis on *informed* rather than *shared* decision-making, the need for leaders and managers to role-model safe and respectful behaviour, and a need to clarify or simplify language in places.

## Conclusions

Based on the findings from these workpackages, we made further revisions to version 2 of the For Us framework to produce a final version of the learning resource. The learning resource is described and presented in Chapter 2, along with the key ways in which the study informed its development.

# Plain-English summary

## Why it matters

Several reviews and inquiries in recent years which have raised concerns about the safety of maternity care in England. In 2022, the Care Quality Commission (CQC) – the regulator for health and social care – began a new maternity inspection programme. It aimed to review all maternity services in England that had not been inspected or rated since April 2021.

In 2023, CQC commissioned The Healthcare Improvement Studies Institute (THIS Institute) and RAND Europe to evaluate the maternity inspection programme. The evaluation had two objectives:

* Identify and describe what good safety culture looks like in maternity and the features underpinning it;
* Look at the maternity inspection programme to learn about how it had been delivered and learn from it to inform the work of maternity services, inspectors, and the health and care system more broadly.

This report describes the work we did to address the first of these objectives.

While much attention is given to what goes wrong in maternity care, a lot of value can be gained by understanding what good looks like. This evaluation produced practical advice on how to improve the inspection programme, and developed a ‘learning resource’ describing the key features of ‘what good looks like’ in safe, high-quality maternity care.

## Our approach

We used a range of different research methods in our work to describe what a good safety culture looks like in maternity services, including:

* reviews of existing publications to help determine what good looks like in maternity safety from the perspectives of maternity service users, staff, inspectors, and other stakeholders;
* workshops with 15 maternity service users;
* an online survey to hear from over 200 people on what good safety culture looks like in maternity care;
* a review of our existing [‘For Us’ framework](https://qualitysafety.bmj.com/content/30/6/444), which first described what good looks like for safe, high-quality maternity care, to develop it with up-to-date insights from the research literature, workshop participants and survey respondents.

## What we found

Some of the features presented in the original [‘For Us’ framework](https://qualitysafety.bmj.com/content/30/6/444) stayed much the same, but some have been changed substantially because of this evaluation. The biggest change is an increased focus on the need for services to work hard to ensure that maternity service users from diverse backgrounds feel understood, heard and included. Linked to this is an emphasis on the active steps needed to ensure that staff, women, and birth partners are treated with respect and listened to regardless of their background. The learning resource strongly emphasises the importance of eliminating racism and any form of discrimination based on ethnic and cultural background both between colleagues and between staff and maternity service users.

The learning resource outlines eight features:

* Commitment to safety and improvement at all levels, with everyone involved;
* Technical competence that is attentive to diverse health needs and supported by formal training and informal learning;
* Optimised teamwork, team communication and coordination;
* Constant reinforcing of inclusive, respectful, and ethical behaviours towards all colleagues and all maternity service users;
* Clear, respectful communication that is culturally competent and accounts for diversity, and permits informed decision-making by maternity service users;
* Multiple approaches in place to detect problems, used as a basis for action, and supported by active nurturing of the conditions for psychological safety;
* Structures, systems, and processes designed for safety and regularly reviewed and optimised, guided by human factors/ergonomics principles where appropriate;
* High-quality leadership and management.

The learning resource helps to identify and describe these features of high-quality care. It offers an important step towards building a shared understanding of ‘what good looks like’ in safe, high-quality maternity care.

# Introduction

In April 2023, the Care Quality Commission (CQC) commissioned The Healthcare Improvement Studies Institute (THIS Institute) at the University of Cambridge, together with RAND Europe, to undertake an evaluation study of CQC’s national maternity inspection programme. The inspection programme involved the inspection and rating of all NHS acute hospital maternity services that CQC had not inspected or rated since April 2021, focusing on two of CQC’s five domains of quality: ‘well-led’ and ‘safe’.

The evaluation had two specific objectives, aligning with CQC’s intentions in commissioning it:

1. To characterise what good safety culture looks like in maternity services and the factors underpinning it;
2. To evaluate the national maternity inspection programme to maximise learning for maternity services, inspection, and the health and care sector more broadly.

The aim was that the study would help to inform CQC’s approach to inspecting, rating and assessing services in maternity and beyond, as well as informing its approach to supporting cultures of improvement, safety and learning in services. The study had a particular concern to improve understanding of inequalities in maternity services. CQC was also interested in developing a resource (e.g. tool, toolkit or framework) to support the improvement of safety culture in maternity services.

In this report, we describe work undertaken in pursuit of the first objective (characterising what good safety culture looks like in maternity services and the factors underpinning it). A companion report describes work relating to the second objective.

## Work undertaken

The evaluation study, designed to run alongside the inspection programme running at the time, took place from May 2023 to February 2024. It involved six mixed-methods workpackages and a final synthesis. Three of those workpackages (A, B and C) related to the first objective (Table 1).

**Table 1: Study workpackages**

|  |  |
| --- | --- |
| **Workpackage** | **Description** |
| **A. A review of what good looks like for maternity safety culture** | Framework-based synthesis of the literature, with a particular focus on equity, diversity and inclusion |
| **B. Participatory workshops with maternity service users** | Facilitated workshops to engage the perspectives of those who use maternity services on the key features of high-quality maternity care identified to date, with a particular focus on securing the views of those from marginalised or minoritised backgrounds |
| **C. Consultation survey with stakeholders** | Online survey to further consult on the key features of high-quality maternity care and gain further suggestions for modification |

Chapters 3 to 5 of this report present high-level summaries of each of these workpackages. In keeping with the preferences of CQC, these chapters are short, with methodological and technical information kept brief. However, further detail can be found in working papers (available to CQC on request) used to prepare the summaries.

Chapter 2 of the report presents the key output of our work: an optimised ‘learning resource’ which brings together the learning from all three workpackages to identify and characterise the key features of safe, high-quality maternity care, from multiple perspectives. **Along with the executive summary, Chapter 2 is likely to be most useful to readers with a principal interest in the evaluation’s first objective (characterising what good safety culture looks like in maternity and the factors underpinning it).**

## Developing the learning resource

A key aim of this part of the study as a whole was to develop what we ultimately termed a **learning resource** (previously referred to variously as a framework or toolkit) to capture the key features of high-quality, safe maternity care in a way that:

* reflected the views of a wide range of stakeholders;
* provided specific, concrete examples, not just abstract concepts of quality and safety; and
* would be useful to a range of stakeholders, ranging from civic society groups through to maternity services, as well as to CQC itself in its work of inspection, regulation and support.

Our starting point in developing the learning resource was a previously published framework, known as the ‘For Us’ framework, first published in 2021.1 For Us had set out seven key features of safe maternity care based on extensive study (including observations and interviews) and consultation on what good looks like in high-performing maternity units. Through the course of the workpackages described in this report, we sought to further refine ‘For Us’, enhancing it with insights from the wider literature, from workshop participants, and from respondents to the consultation survey.

Chapter 2 presents the final version of the learning resource, and summarises the key ways in which the findings from the evaluation informed its development.

## Study governance

The evaluation benefitted hugely from the input of an advisory group comprising members from service user, medical, midwifery, managerial, academic and inspection backgrounds. The group met three times during the study, advising on evaluation design, data interpretation, and dissemination among other things. In addition, workpackage B drew on extensive input from one advisory group member, Zenab Barry, who contributed to workshop design, management, recruitment, and facilitation. The eight members of the advisory group were:

* Zenab Barry
* Tim Draycott
* Teresa Kelly
* Tony Kelly
* Victoria Komolafe
* Devender Roberts
* Susanna Stanford
* Justin Waring

The evaluation also benefitted from the assistance and input of CQC, for example in relation to feedback on drafts and advice on the format that outputs should take. We are grateful to Alison Thwaites and Ian Russell for timely and helpful advice throughout the study, and for coordinating input and feedback from other colleagues in CQC when needed.

### Ethical considerations

This evaluation involved multiple discrete sub-studies adopting a range of methodological approaches, and so tailored approaches to ethical and governance approvals for each sub-study were needed. Since workpackage A involved literature review only, no ethical approval was required.

For workpackages B and C, we used the Health Research Authority’s decision tool to determine whether ethical approval was required. Following the recommendations of the tool, we sought and were granted approval for workpackage C (consultation survey) from the University of Cambridge Psychology Research Ethics Committee. Workpackage B (participatory workshops) was deemed to be patient and public involvement and engagement, and therefore did not require ethical approval. Across all workpackages, recruitment and data collection did not involve NHS organisations.

### Agreed modifications

The evaluation largely followed the plan outlined in the Quality Response document submitted to CQC in response to its invitation to tender. Some minor changes were made to the study as it proceeded, in discussion with CQC, as follows:

* Originally, we proposed to develop a revised iteration of the learning resource at several points. In practice, workpackages B and C ran alongside each other rather than sequentially, and so each took the version of the learning resource presented in the interim report (October 2023) as its starting point.
* We originally proposed that the consultation survey (workpackage C) would focus solely on staff and system stakeholders. We subsequently identified that it would also be valuable to invite service users to comment on the features of safe, high-quality maternity care through this survey (as well as in the participatory workshops of workpackage B), and so we broadened the inclusion criteria for the survey.
* What we now call the learning resource was given different labels at earlier points in the study. In the Quality Response it was referred to as a ‘draft prototype framework’, and then subsequently as a toolkit. These earlier terms had potential to cause confusion (e.g. with frameworks used to guide inspections) and neither fully captured the purpose described above. We agreed with CQC that the term ‘learning resource’ better described both the strengths and the limitations of this output, highlighting the breadth of its potential while avoiding suggesting that it was ready for deployment by inspectors, healthcare organisations, or other stakeholders.

### A note on language

We recognise that not everyone who is pregnant or gives birth identifies as a woman. The term ‘maternity service user’ is used inclusively in this report, including pregnant and birthing people and their birth partners. Although we do use the words “woman” and “women”, we aimed throughout the study to be inclusive of the views of all people who have experienced pregnancy, labour and birth, including women, trans and gender-diverse people.

# The learning resource on what good looks like

This chapter presents the final version of the learning resource produced in the course of this work and outlines the key points in its development. Later chapters in the report provide greater details on those development stages and what they added to the resource. Here, we first briefly summarise the process, then present the resource, and then identify the key ways in which it differs from the earlier versions.

The learning resource has a basic and fundamental aim: to articulate a common vision of what good looks like that integrates the views of the range of stakeholders, providing a common starting point for the work of professionals, managers, organisations, women and birth partners, service user organisations and regulators as they strive to put it into practice. An important note is that, while the resource seeks to describe the features of high-quality care and to incorporate the perspectives of the full range of stakeholders in this description, **it is not suitable for use in quality assuring or inspecting services, and nor does it provide a tool for achieving the features described**. It is for other organisations to take these features as a starting point.

Further, the learning resource we present here is the final version for the purposes of this report, but it should still be considered provisional. As we note in other chapters, the learning resource could be subject to further development work to further enhance its validity, comprehensiveness and legitimacy with stakeholders.

## The development of the learning resource

As described in more detail in later chapters of this report, the development of the learning resource took place over several stages, with three major iterations as follows.

* Our starting point was **the For Us framework**.1 This framework, developed using insights from extensive mixed-methods fieldwork in high-performing maternity services, set out seven features of the culture of high-performing, safe maternity units.
* Since some years have passed since the development of For Us, we sought to update it by reviewing the literatures relating to two important areas: first, maternity safety culture; and second, the experiences of maternity service users, especially those from minoritised or otherwise disadvantaged backgrounds.
* Synthesising the insights from these literatures, we produced a **revised version of the For Us framework**. The content and configuration of some of the features was revised, with issues relating to equality, diversity and inclusion foregrounded, and an eighth feature (relating specifically to high-quality management and leadership was added). This is presented at the end of Chapter 3.
* We sought to sense-check, validate and enhance the revised version of For Us through two activities, using the insights to develop the final version of the learning resource presented in this chapter:
  + a series of **three participatory workshops** with maternity service users (particularly those from marginalised backgrounds) (workpackage B, described in Chapter 4). The insights from these workshops were particularly important since the literature reviews (Chapter 3) showed that only limited attention had been given in existing evidence to the views and experiences of minoritised and marginalised groups.
  + a **survey of stakeholders** with an interest in maternity care from a wide range of backgrounds (workpackage C, described in Chapter 5). The findings suggested that the revised For Us framework resonated very well with a range of audiences in the way it sought to articulate what good looks like for maternity service users and staff. However, respondents did have some suggestions for enhancing it further, which we addressed alongside those arising from the workshops.

## The final version of the learning resource

The final version of the learning resource is presented below. This is a ‘medium-length’ version, offering the same level of detail as provided to contributors to participatory workshops in workpackage B, and to respondents to the survey in workpackage C. Both longer versions (drawing on a full range of literature) and shorter versions (tailored to different audiences, and potentially using different forms of language or different modalities of presentation) can be derived from this medium-length version.

The major ways in which this version differs from and builds on the two previous iterations are described later (in section 2.3 below).

### Feature 1: Commitment to safety and improvement at all levels, with everyone involved

What this looks like:

* A strong commitment to safety and improvement is found at all levels and in all roles. It is clear in the behaviours of all.
* Safety is understood in a broad and inclusive way, incorporating the importance of listening to women, choice, care and kindness.
* Commitment is matched by action, including action to address inequalities.
* All staff feel a shared sense of ownership and responsibility for safety and improvement within the unit.
* Staff work proactively with service users and with colleagues across the maternity service pathway to keep mothers and babies safe.
* Those using services feel confident that there is a shared commitment to safety and improvement.

### Feature 2: Technical competence that is attentive to diverse health needs and supported by formal training and informal learning

What this looks like:

* Staff have strong technical skills, including the clinical skills of the different professional groups involved in care.
* As well as strong technical competencies, staff have strong “non-technical” skills, such as those relating to teamwork and communication.
* Standards of practice are evidence-based.
* The expectations of practice are clear and well understood by all staff.
* Staff recognise diverse health needs, for example relating to people’s backgrounds and ethnicity, and can address them effectively.
* Standards of practice and technical and non-technical skills are consistently reinforced through high quality training, with protected time available for participation, with backfill provided as needed.
* An ethos of learning is everywhere, with newcomers socialised into expectations of safe behaviour and practice.
* Multiple opportunities are available to learn, with colleagues explaining not just “how” but also “why” and allowing each other to develop their skills through reflective practice.

### Feature 3: Optimised teamwork, team communication and coordination

What this looks like:

* Team members have clearly defined roles and responsibilities.
* Leadership is effective and inclusive. It ensures the voice of maternity service users is heard and that they are recognised as members of the team.
* Appropriate use is made of tools, techniques, and systems to support communication, coordination, and situation awareness.
* Clear protocols and systems are in place for handling obstetric emergencies, including clear lines of responsibility and well-understood approaches to coordinated responses.
* Training emphasises teamwork and uses evidence-based techniques such as simulation.
* Speaking up is strongly encouraged – colleagues and maternity service users all feel comfortable in speaking about concerns or making suggestions.
* Those using services, including women and birth partners, feel part of the team and that they too can contribute to safety and improvement.

### Feature 4: Constant reinforcing of inclusive, respectful and ethical behaviours towards all colleagues and all maternity service users

What this looks like:

* A positive vision and commitment to inclusive, respectful and ethical behaviours is constantly articulated and backed by well-founded procedures and action.
* Efforts are made to reduce situational triggers to stress, conflict and tension where possible.
* Professional boundaries and differences of opinion are managed effectively to reduce conflict while demonstrating respect for differing views.
* Communication is respectful, honest, two-way and inclusive. It is devoid of racist language and discriminatory attitudes or behaviours towards anyone.
* Those who use services and, where appropriate, their birth partners are recognised as partners in high-quality care.
* The preferences and choices, including religious and cultural preferences, of those who use services are respected, and where possible incorporated into care. Staff have time to understand and enact these preferences.
* Transgressive behaviour (including disrespect and discrimination) is noticed and dealt with effectively, with support from high-quality management and HR (human resources) systems to address problems promptly, fairly and with determination.
* Anti-racist policies and anti-racist practices are understood and embraced by all staff along the maternity care pathway.
* Colleagues routinely demonstrate that they value one another’s contributions, for example through noticing what they do and expressing appreciation.
* Colleagues can raise concerns with, and challenge, one another in a respectful way.
* Those using services feel comfortable and confident that they will be cared for respectfully and inclusively, that they can raise concerns if needed, and that concerns will be addressed.

### Feature 5: Clear, respectful communication that is culturally competent and accounts for diversity, and permits informed decision-making by maternity service users

What this looks like:

* Expectations of good practice in relation to communication that is inclusive and respectful of diversity are clear, shared by all, and supported by high quality training and role modelling.
* Information is two-way, with professional information (clinical knowledge about options available and the evidence on their benefits, harms, and uncertainties, along with professionals’ experience of different options) and personal information (including life circumstances, values, and preferences) all considered. Staff have time to understand and enact these preferences.
* Staff provide evidence-based information clearly and impartially, listen closely to the questions, preferences and decisions communicated by maternity service users, and respond to them in a clear and impartial way.
* To support informed decision-making, people using maternity care are given clear information about their care, which is communicated in plain language without jargon and in culturally appropriate ways and supported by interpretation services where needed.
* People using care are encouraged to ask questions and given as much time as feasible to consider their options so they can make choices and give informed consent.
* People using maternity care are asked about any concerns in a manner that conveys a sincere desire to hear from them. Clear information about how to raise concerns is available.
* Cultural awareness training for staff encourages awareness of their own biases and the impacts on care.

### Feature 6: Multiple approaches in place to detect problems, used as basis of action, and supported by active nurturing of the conditions for psychological safety

What this looks like:

* “Problem-sensing” behaviours are strongly encouraged, with the full range of techniques for discovering issues, concerns, and risks deployed.
* Multiple approaches are used to identify potential risks to safety and concerns of staff or services users about the service.
* Data and analyses are made available to frontline staff to help them improve their practice.
* Clinical data, including socio-demographic characteristics such as ethnicity, are routinely recorded, analysed and used improve the quality of services.
* Colleagues are alert and sensitive to “soft” signs of problems that may be difficult to articulate or quantify. This involves listening to those at the frontline of care and using a range of techniques to diagnose risks.
* Maternity service users and their birth partners, are encouraged to share ideas and concerns, with appropriate attention to diverse preferences and abilities.
* Systems, processes and procedures for staff and maternity service users to raise concerns, offer suggestions, make complaints or provide other forms of feedback are clear, well publicised, understood by all, and consistently applied.
* There are clear processes, with associated responsibilities and timelines, for acknowledging, acting on and responding to concerns, complaints, and feedback.
* All colleagues, including but not only those in senior positions, cultivate ‘psychological safety’ – the “belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes”.
* When there are problems, there is transparency about what has gone wrong and what is being done to address it.
* Organisations and the wider healthcare systems need to respond to and learn from incidents when they happen, ensuring that maternity service users and families affected by a patient safety incident have their voices listened to, their questions addressed and their needs met.

### Feature 7: Structures, systems and processes designed for safety and regularly reviewed and optimised, guided by human factors/ergonomics principles where appropriate

What this looks like:

* The working environment, including processes, systems and structures, is purposefully designed and optimised to help people to perform at their best.
* The approach taken emphasises the importance of human factors/ergonomics, which is based on the principle that system and human performance can be improved through an integrated and systematic approach to individual skills, teamwork, equipment, task, environment, and organisational design.
* Equipment, space, information and procedures are all optimised to reduce the cognitive demands on staff (allowing them to focus on the things that really matter in delivering safe care), reduce physical demand, and enhance safety.
* Improvements are developed in partnership with staff and maternity service users, using co-design methods where possible and appropriate.
* System design accounts for diversity, including (but not only) the needs of minoritised groups and those who are socio-economically deprived.
* Standards, processes and systems are continually reviewed and adapted as technology and circumstances change and new information or evidence emerges.
* Appropriate methods, including simulation, are used to test the usability and impact of new systems or improvements of existing ones.

### Feature 8: High quality leadership and management

What this looks like:

* The importance of high-quality leadership and management as a defining feature of a safety culture is recognised and is clearly visible in practice.
* Leaders and managers are role models, embodying the behaviour they expect of others, listening attentively and appreciatively to the suggestions of their colleagues and of service users, acting on suggestions when it is appropriate, and explaining their reasons when it is not.
* Leaders and managers set a clear, ambitious, and meaningful vision which inspires people by focusing on the things that matter to service users and staff and aligns efforts around that goal.
* Leaders and managers are champions for maternity services in wider organisations and systems, ensuring that safety is prioritised across pathways and seeking to ensure that maternity services receive the resources they need.
* Management systems and practices are sound and effective, underpinned by high quality risk management systems and HR (human resource) management systems.
* Leaders and managers engage in a meaningful way with marginalised and minoritised groups, including socially disadvantaged and ethnic minority communities, to improve the quality, safety and inclusiveness of services for these groups.
* Leaders and managers foster psychological safety among all staff and maternity users, so people feel safe to speak up when needed.

## Key points of development from the original For Us framework and the new learning resource

Some of the features presented in the previous section changed substantially as a result of the work of this part of the evaluation; others changed more incrementally and a few changed very little.

The most notable change of all, and one that permeates all the features, is a markedly increased focus on the need for inclusion of maternity service users from diverse backgrounds. Linked to this is an emphasis on the active steps needed to ensure that staff, women and birth partners are treated with respect and listened to regardless of their background. The updated resource strongly emphasises the importance of eliminating racism and any form of discrimination based on ethnic and cultural background both between colleagues and between staff and maternity service users.

The increased prominence given to equity and inclusion was supported by all elements of our study, including the literature review, the participatory workshops, and the survey. The literature review highlighted that people from minority ethnic backgrounds have persistently poorer maternal and infant outcomes and experiences of care, and that problems with maternity services themselves contribute to these outcomes—i.e., they cannot solely be attributed to ‘background’ disadvantage faced by minority ethnic groups. This focus was strongly endorsed by contributors to the participatory workshops. Some survey respondents queried the specific focus on racism and racial discrimination and drew attention to the importance of other protected characteristics, and of deprivation more broadly, including its contribution to inequalities in maternity outcomes. However, given current evidence from confidential inquiries 2 and other sources, we have retained this focus in the final version of the learning resource.

Other major changes and their justifications are highlighted below. The following chapters provide more detail on the analyses that informed these changes.

* Contributors to participatory workshops and respondents to the survey highlighted the importance of attending to safety across the care pathway (not just during labour and birth). They identified the interdependence of services providing perinatal care of various kinds, and noted that preparations for a safe birth start at the first point of contact with the health system during pregnancy and that antenatal services also have a crucial part to play. We have addressed this with an additional point under Feature 1, and by adding to the way we characterise high-quality leadership and management under Feature 8.
* Those participating in both workshops and the survey also felt that the place and voice of the maternity service user could be further strengthened. The final version of the learning resource, accordingly, further foregrounds the maternity service user’s role, including for example their place as part of the team (Feature 3) and the need to ensure transparency with maternity service users (as well as openness of learning within systems) when things go wrong (Feature 6).
* Workshop participants also felt that greater emphasis should be given to the inclusion of the birth partner and recognition of their needs for care; some modifications have been made to account for this point (for example under Feature 3).
* A particular point made by multiple survey respondents was that the language regarding respect for the autonomy of the woman giving birth needed to be enhanced. Feature 5 has therefore been rephrased to refer to *informed* decision-making rather than shared decision-making; some of the items included under this feature have also been changed, accounting also for a consistent call from participants in the workshops for an emphasis on two-way communication: on listening as well as clarity. The language in some other places has also been adjusted—for example, in relation to respect for religious and cultural preferences (Feature 4).
* The eighth feature—‘High quality leadership and management’—received little input from the workshops but did receive some commentary from survey respondents. It has been adapted to include key suggestions regarding the need for role-modelling good behaviour, and acting as a champion for maternity services.
* Workpackage C suggested that there was a lack of clarity for some respondents in relation to some of the terms used: for example, ‘technical skills’ in Feature 2, and ‘problem-sensing’ systems in Feature 6. The final learning resource seeks to clarify these terms.

# Literature review on what good looks like for maternity safety culture (workpackage A)

The first workpackage in the evaluation sought to draw lessons from the existing literature on what a high-quality, effective safety culture might look like in maternity. While a great deal has been written about the characteristics and impacts of adverse safety cultures, there is also great, and to date untapped, value in identifying what ‘good’ looks like. The aim here was to contribute to informing how CQC can better assess, inspect, analyse and support cultures of safety and learning, both within maternity care and more broadly.

## Methods

This workpackage combined two approaches to literature review to secure maximum insight from the available academic and grey literatures.

### Equality, diversity, inclusion and service users’ experiences: best fit synthesis

We used a best fit synthesis approach3 to review the literature on service users’ experiences of maternity care, with a particular focus on literature addressing the experiences of minoritised and socially disadvantaged groups, and the literature that examines the cultures of maternity services with regard to equality, diversity and inclusion. We used a framework originally created by the National Academy of Medicine (formerly the Institute of Medicine)4 and further developed in the context of maternity care by some of the authors of this report5 to organise the findings from the literature.

For this synthesis, we identified 817 unique items from bibliographic databases, supplemented by a further 37 items (policy papers, position statements from professional bodies, research reports, as well as some news items) from Google and hand searching. In total, 77 sources were included in the review, including 20 literature reviews and 57 empirical research-based studies and reports.

### Maternity safety culture: author-led review

Building on this work, we also used an author-led approach6 to review the literature on maternity safety culture. Here, we took as our starting point the For Us framework, which is a well known, evidence-based framework which sets out seven features of safe maternity units based on a large multi-method study. Since the framework is now over three years old, and extensive additional literature has been published on maternity safety and safety culture, we sought to update it using more recent insights from the academic and grey literatures. This involved an iterative approach to identifying and synthesising literature based largely on the embodied expertise of the review team, including our deep familiarity with the literature.

Our choice of this approach was guided by the nature of the literature, which is vast and often poorly indexed, and by the nature of the task, which required an interpretive approach where creative and critical reasoning could be drawn on in identifying and including relevant materials, with the aim of generating a practically useful overview of a potentially boundless area. This also involved using the literature identified in the best fit synthesis to enrich the For Us framework, In the process, we sought to further develop the For Us framework, resulting in the first iteration of what was to become the learning resource. The author-led review drew on around 200 sources from the academic and wider literatures, including empirical studies in maternity care and other areas of health service delivery, theoretical pieces, analyses from other areas where problems of culture and behaviour have posed challenges to safety, and studies of related areas such as teamwork, interprofessional relationships, and person-centred care.

## Key findings: equality, diversity, inclusion and maternity service users’ experiences

Our review of this literature found considerable gaps in knowledge, particularly in relation to the influence of ethnicity on maternity service users’ experiences. Quantitative data relating to ethnicity are often lacking,7,8 and more broadly, major investigations have not generally given specific attention specific experiences and outcomes of minoritised and socially disadvantaged groups.8 Nevertheless, the existing literature does show that minoritised and socio-economically disadvantaged women are adversely affected by intersecting factors (including racism, language challenges, cultural differences, poor competence, stereotyping and assumptions, and structural barriers) that result in worse outcomes and experiences. Socio-economic and demographic patterns play a key role in these patterns of outcomes and experience, but over-reliance on this explanation may obscure the contribution of poor care for these groups. In other words, systematically worse outcomes for minoritised and marginalised groups are not the product of their social disadvantage alone: in some cases, this appears to be exacerbated by the healthcare system. Indeed, attribution of poorer outcomes and experiences solely to socio-demographic explanations may mean that problems in healthcare services and systems, including institutionalised racism, may be obscured so that they are allowed to persist.8,9

### Quality of maternity care for minoritised and disadvantaged women

Mapped against the domains of quality,1,5 it is clear that some groups experience substantially inferior care across domains. In relation to **equity and inclusion**, for example, despite a range of policy initiatives,10,11 those from marginalised and minoritised backgrounds experience persistently poorer care, due for example to poor cultural sensitivity and ‘othering’ by healthcare staff.7,9 The nuances of women’s beliefs, needs and requests are often lost, overlooked or not taken seriously by maternity services and staff, and ethnic groups are stereotyped as homogeneous.12 Immigrant women may be disadvantaged because of assumptions about their experiences, expectations of care, capabilities and needs.13,14 Women with disabilities report that they felt they were a ‘spectacle’ or abnormality.15 Heterosexism of services, reinforced through maternity literature and documentation, has been reported by lesbian mothers.16

In relation to **efficiency and timeliness**, there is evidence of approaches that may cause delays in care with potential implications for safety. Issues relating to effective communication, for example lack of access to interpretation services, can make it harder for migrant women to communicate their health care needs and therefore result in delayed access to services.17 **Effectiveness** of care for minoritised groups may be compromised by failure to draw on scientific knowledge about the distinctive health needs of people of different ethnic backgrounds.9 For instance, evidence about increased risks in pregnancy or labour for some minoritised groups does not always result in adequately customised services. For example, there is evidence that women from ethnic minority backgrounds may have an increased risk of postpartum haemorrhage and that perinatal care needs to account for this.18 These issues extend to the full perinatal period, for example in relation to identifying and treating postnatal depression.8

In relation to **safety**, the literature we reviewed demonstrates that people of minority ethnicity do not feel safe, physically, culturally or psychologically,19 during their maternity care. Women from minoritised groups may be exposed to avoidable harm;7-9,20 they may find their concerns dismissed or not taken seriously;7-9,21,22 they may not be able to articulate their concerns as effectively as more advantaged women, for example because of language difficulties 23 and lack of trust and rapport with health professionals.24-26 They may find themselves being sent home in labour, because of not being believed;27 they may receive insufficient monitoring of risk;8 and they may get insufficient attention to their specific health needs.8,28

All groups may face challenges in the **accessibility** of services, but again these challenges may be particularly impactful for those from disadvantaged or minoritised backgrounds, across the maternity care pathway. For example, women with complex social factors (which may include poverty, young mothers, some ethnic groups, substance use, non-English speaking, mental health problems) are in greater need of antenatal support but may find this harder to access and engage with.29

While **person-centredness** has been repeatedly identified as critical to high-quality care, those from minoritised backgrounds may face care that is disrespectful, lacks personalised information, and fails to listen closely. Women reported that their care felt like a ‘conveyor belt’, and was rushed and impersonal, focusing on the priorities of the healthcare professional or the organisation rather than those of the woman.22,26,27 Stereotyping again may play a role in these poorer experiences: for example, in ideas that black women have high pain thresholds or that women from some cultures have close family ties that will help with breastfeeding and therefore do not require support from the maternity services.9 Similarly, the literature identifies multiple ways in which women from minoritised backgrounds are denied **choice and continuity**. These include not being offered a female health professional; not having their birth plans taken seriously; not having religious beliefs and needs acknowledged and respected; not having their options explained at all (e.g. on place of birth) or not having options explained with sufficient information in a way that they could understand to enable a real choice.28

### What good might look like for minoritised and disadvantaged groups

The literature also contains many suggestions and recommendations for improving the quality of maternity care, including some which seek to address these disparities in quality, experiences and outcomes for marginalised groups specifically. An analysis of the likely effectiveness of these interventions is beyond the scope of our review. However, some of the actions suggested that might have potential to improve equity, diversity and inclusiveness include:7-9,30

* Building on strategies that have encouraged ethnic minority women’s participation in maternity research, for example, multilingual resources, material that is culturally appropriate, or material that recognises that some conditions are stigmatised in some cultures.
* Delivering the existing Better Births commitments31 regarding, for example, continuity of carer if appropriate, choice and personalised care, and the right to change caregiver.
* Investing in meaningful co-production throughout policymaking, led by Black, Asian, minority ethnic and other minority people.
* Improving the clarity of the complaints process and offer support to women and families through an independent advocate, e.g., maternity care patient support groups.
* Ensuring that local Maternity and Neonatal Voices Partnerships engage ethnic minority women, ensuring that voices of local populations are represented according to ethnic sub-groups (e.g., ‘Bangladeshi’, ‘Somali’, ‘Arab’, ‘Pakistani’, rather than ‘Black’, ‘Asian’ etc.)
* Improving recording of ethnicity of compensation claimants in NHS Resolution’s claims management system and publishing this data in its annual reports, which should include ethnicity profiles for the different clinical areas.

## Key findings: advancing understanding of what good looks like for maternity safety culture

Using the original For Us framework as our starting point, we sought to collate findings and ideas from the vast literatures covered by our author-led approach in a way that ensured specificity and relevance to maternity care. We updated the For Us framework in light of learning from the literature outlined in section 3.2, the wider academic literature on safety culture, and the recent work by the Royal College of Anaesthetists on National Safety Standards for Invasive Procedures, which included a major focus on organisational context and patient involvement.32 We also incorporated the key findings from our best-fit synthesis of the literature on equality, diversity and inclusion in maternity care (summarised above), though, as we note, the evidence base for the features of safety as it applies to minoritised groups remains under-developed.

Together, our analysis of these literatures led us to update and enrich the features of the For Us framework, particularly in relation to how the features might account for diversity, equality and inclusion, and seek to include activities to address the systematically poorer experiences and outcomes of care for minoritised women described above. The updated version of the For Us framework thus included modified headings and descriptions, and also brought the addition of an eighth feature, ‘High quality leadership and management’, recognising the importance of accounting for the role of leaders and managers across organisation in securing safe and inclusive cultures of care.

**This ‘version 2’ of the For Us framework represented the next step in our development of the learning resource** presented in Chapter 2. It provided the basis for further engagement, consultation and discussion of the features in our participatory workshops (workpackage B, Chapter 4) and survey (workpackage C, Chapter 5). Version 2 of For Us is presented as an appendix to this report.

# Participatory workshops with maternity service users (workpackage B)

In workpackage B, we sought to challenge, expand and enrich the revised version of the For Us framework produced following workpackage A, summarised in section 3.3 and in the appendix, by bringing it before diverse groups of maternity service users. The literature reviews presented in Chapter 3 showed that many women, particularly those from minoritised groups, experience maternity care in the NHS that lacks cultural sensitivity, kindness and attentiveness to individual needs. We wanted to hear diverse perspectives on what good maternity care looks like (or would look like) and to test out the eight features of maternity unit safety that formed the revised For Us framework, developing it further towards the comprehensive learning resource that we present in Chapter 2.

## Methods

We sought to elicit the views of maternity service users through a series of workshops, two online and one in-person, with a particular ambition to include people whose views are often not heard or addressed. Working with our advisory group (see section 1.3), we devised a flexible workshop-based format that could allow participants to describe their own experiences, to consider what good looks like in maternity care, and to comment directly on the For Us framework and the extent to which it reflected their own priorities for safe, high-quality maternity care.

We used a combination of network-based and purposive sampling (including targeted social media and direct recruitment through third-party organisations that support women and pregnant people through pregnancy) to recruit participants from across England, proactively targeting minoritised ethnic communities. Fifteen women attended the three workshops in total, including two from Asian or Asian British backgrounds, eight from black African, black Caribbean or black British backgrounds, one of mixed heritage, and four from white backgrounds.

## What good maternity care looks like

Each group was asked to reflect on their experiences of maternity care, including what they liked and valued, what they wished could have been different, and what changes they would make. The groups produced summaries of their vision of what good maternity care would look like.

Many participants were able to recount positive experiences. They valued continuity of care (from the antenatal period through to postnatal care), feeling welcome, being cared for as individuals and being offered genuine birthing choices and explanations. They also appreciated the efforts that staff made to create a sense of safety, order and calm, especially in emergency situations. However, not all their experiences were so positive, and the negative experiences were also important in identifying what was really needed to ensure that good maternity care was experienced by all, regardless of background.

### A broad and inclusive definition of safety

Notwithstanding their positive experiences, a common issue for women in the workshops was not feeling safe. Their notion of safety extended well beyond the clinical to encompass psychological safety, cultural safety and other forms. The literature review presented in section 3.2.1 notes the failure of maternity services to provide these wider facets of safety for people from minoritised backgrounds in particular, and the revised For Us framework described in section 3.3 and in the appendix begins to account for it. However, as we note in section 4.3 below, workshop participants urged us to go further. They had found during their experiences of maternity care that their cultural and religious traditions were not always upheld, that their wishes were not always respected, that important clinical details were not always acknowledged and addressed, that they were not always listened to, and that that their needs and their birth partners’ needs were not always met. This left them feeling vulnerable and reliant on their own ability to advocate for their needs.

Participants made the case that safety needed to go beyond the clinical. The current construction of safety in the NHS seemed to many women to be too risk averse, too narrow, too focused on the baby alone rather than also on the mother and the wider family. A narrow definition of safety, they reported, could lead to coercive language and an absence of real choice. They wanted maternity services to feel safe and not just to comply with a technical definition of safety, so proposed that a broad definition of safety was essential across the whole maternity journey from antenatal care, through labour and birth and on into the postnatal period.

Workshop participants called for a broad and inclusive definition of safety that included, but was not limited to, clinical safety, and that encompassed psychological safety (for women, birth partners and staff), physical safety (e.g. safeguarding, accessible and welcoming facilities) and cultural safety (e.g. an environment free from racism and discrimination).

### Making choice and person-centred care real

Many participants had found that shared decision-making was not the norm in maternity services. They recounted that they had not been given the opportunity to ask questions and to discuss their options. Instead, many felt that decisions had been made by staff about what was safe or appropriate regarding the mode of birth. They reported that information was presented in a manner intended to direct them towards a particular option – and with limited opportunity to decline this option, even in an informed way. Women felt many health professionals were not open to sharing evidence with them and negotiating an appropriate course of action based on the relative safety of different options and their beliefs and preferences.

Feeling cared for and feeling treated as an individual were important parts of feeling safe for participants. Women wanted to be treated as individuals undergoing a new experience, even if this was not their first baby. They often felt that they had to advocate for themselves and that no-one was looking out for them, especially postnatally. They felt this was very risky, especially in relation to their mental health, again emphasising that this was not just a matter of high-quality service user experience, but of service user safety too. Participants offered experiences of care that fell well below the standard that might be expected. Echoing stories that are depressingly familiar from the literature summarised in section 3.2.1, they gave examples of care that appeared racist and unprofessional. Participants expressed frustration with inflexible policies and the lack of facilities to support birth partners during labour, and at the way in which care seemed to fall off after the birth and through the postnatal period, both in hospital and in the community.

At the same time, participants recognised the constraints faced by services and staff in realising this vision. Participants acknowledged that midwives were motivated to give women and their birth partners a positive experience of labour and birth that took into account individual needs and preferences. But, they noted, they were over-stretched and suffering compassion fatigue to the extent that many were no longer able to provide the care they wanted to.

## Comments on the draft learning resource

Using an abridged version of the modified For Us framework presented in section 3.3 (one that avoided technical language) we asked women to consider what they liked or disliked about the features, which features they would prioritise in a learning resource, and how the features related to the group’s summary of what good care looked like. The framework as a whole had some face validity for participants, but they had specific comments on several of the individual features, and felt that more work was needed across the framework to do justice to the construction of safety that they had articulated. Here we highlight the features where they offered the most extensive critique: features 1, 4 and 5.

### The modified For Us framework as a whole

Participants identified some deficiencies and omissions in the overall framework and the way it was presented. Some noted the absence of birth partners, whose inclusion was an important part of the group’s vision of safe, high-quality care. Other participants suggested that more could be done to foreground the view of the service user. For example, as one participant suggested, reference might be made to ways in which staff could see services through service users’ eyes, such as the ‘Fifteen steps challenge’.33 Some participants also noticed tensions between the domains covered by the eight features (for example, women might have a negative experience of their care because of disrespectful behaviour by staff even in what was technically a safe and efficient organisation), and emphasised the importance of ensuring that organisations handled those tensions appropriately.

The fourth and fifth features of the modified For Us framework, relating to respectful and inclusive behaviour and high-quality communication, resonated most strongly with workshop participants. However, they felt that these features did not go far enough. For example, behaviour itself is an important form of communication, and communication must be two-way: not only must information be imparted clearly and accurately, but staff and organisations need to create opportunities for women to speak, must listen to what they say with an open mind, must respond appropriately, and must close the loop to show that they have listened.

### Feature 1: Safety is central and involves everyone

Participants in all three workshops welcomed this feature but, as noted above, were adamant that the definition of ‘safety’ needed to be broad and comprehensive. Safety did not just mean clinical safety, although this was very important. Safety also meant that maternity staff asked women questions about aspects of their home circumstances (for example, intimate partner violence) throughout maternity care and that organisations were committed to addressing “ingrained attitudes and prejudices and things like that that stop things from being safe” in areas like maternal mental health.

Participants emphasised the need to understand safety as just one aspect of high-quality care – and one that should not trump choice and experience, or override other aspects of care that were important to them such as being cared for, feeling respected, and seeing that their wishes and choices counted.

### Feature 4: Staff behave in a respectful and inclusive way

Participants strongly supported the inclusion of respectful behaviour and communication in the list of features. Some participants suggested that these were, to them, the most important ones in the list. When considering this feature, workshop participants gave many examples of care that had felt disrespectful or that had left them feeling that women who did not ‘fit in’ to the standard care pathway were seen by some staff as a nuisance and that provision was not made for them. Some suggested that feature four (as well as feature five) needed to refer to shared decision-making because staff behaviour was also a form of communication (communication is not solely verbal). Consequently poor behaviour could hinder discussion and genuine shared decision-making.

### Feature 5: Staff communicate in a respectful and inclusive way and encourage shared decision-making

Participants considered that this feature was one of the most important, especially as women in pregnancy or labour are often feeling extremely vulnerable. They were keen to emphasise that it should be made explicit that good communication is two-way communication. For example, clear explanations of risk were vital, but so too was listening to a woman’s response, and respecting her choices.

Some participants discussed what they perceived as the tendency to scaremonger, although one participant recognised that while information might feel like scaremongering it was necessary to provide what might be difficult information in order for the woman to be able to make a choice. For some, their experiences suggested that maternity health systems worked within narrow parameters based on control and scheduling rather than being able to accommodate more flexible approaches to the patterns of pregnancy, labour and birth. Again, this highlighted the importance of holding the components of high-quality care in equilibrium: like safety, efficiency and effectiveness should not be allowed to dominate other considerations.

## Conclusion

The three participatory workshops proved to offer rich insights into good-quality care in general and how this might be articulated in the learning resource in particular, informed by the lived expertise of a diverse group of women. Sadly, the accounts presented in the workshops echoed the findings of much of the literature summarised in section 3.2.1. Although there were descriptions of positive care, the women also described times where they felt excluded or ignored or were subjected to care that was unkind, clinically unsafe (e.g. in relation to missed or delayed diagnosis) or racist.

Participants gave the eight features of a safe maternity unit from the revised For Us framework a cautious welcome. It was clear that some of the features (notably Features 4 and 5 on respectful and inclusive communication and behaviour) resonated strongly with their own experiences and expectations, even if they did always not go far enough.

Overall, the sense was that the features (as set out in the shorter version used in the workshop) did not fully capture what women wanted from maternity care. Women emphasised aspects of care that only tangentially appeared in the framework (or were subsumed within one feature e.g. clear and respectful communication and shared decision-making). They foregrounded the overall experience of feeling welcome, feeling safe and feeling cared for as individuals. They felt as if at times the bare minimum was provided to ensure the safety of the baby and that other aspects of safety and wellbeing were patchy and under-resourced. The participants argued strongly that safety *is* listening, and that, too often, health professionals did not listen: not, participants felt, because they did not have time (although they were recognised to be over-stretched) but because they did not always want to hear what women were saying. They believed that maternity services should be working under a broader definition of safety, one that was drawn up in collaboration with maternity service users (e.g. through consultation with maternity user groups locally or nationally) and that could be discussed with individual women according to their needs and preferences. Thus care and choice would be foregrounded in maternity services.

As discussed in Chapter 3, we sought to incorporate the spirit and letter of these points in the further revised version of the For Us framework that formed the draft learning resource. There were, of course, some limitations to the workshops. Participants could not (and did not claim to) speak for all maternity service users. They were presented with high-level, accessible versions of the modified For Us framework rather than the full detail it provides in terms of recommendations and descriptions of what good looks like. Nevertheless, their views on what is foregrounded and what is neglected in the high-level headings offer a vital resource for improving it, not least because what it foregrounds will also affect the way that other audiences understand, interpret and make use of it.

# Consultation survey with stakeholders (workpackage C)

Complementing the participatory workshops described in Chapter 4, workpackage B involved a consultation survey with stakeholders in maternity care, designed to elicit their feedback on the revised version of the For Us framework refined via the literature reviews presented in Chapter 3. The survey was key in sense-checking and improving the eventual content of our learning resource, ensuring that it had resonance for and accounted for the views of the wide range of stakeholders affected. In addition to the professional stakeholders originally envisaged in the proposal to CQC, we also included maternity service users in the survey, adding to the voices heard in the participatory workshops. The survey was open from 9 January to 12 February 2024, and received 215 responses.

## Methods

Through an iterative process we designed a survey tool that asked respondents to comment on the eight features of the revised For Us framework as a whole, and then (if they wished) to offer more detailed feedback on one, several or all of the individual features. Questions took a variety of categorical, ordinal and free-text forms. Respondents were recruited through a variety of routes, including social media messages from THIS Institute, CQC and other organisations, direct e-mail contact with individuals with an interest in maternity care who had consented to receive such material, and recruitment through stakeholder organisations. Respondents were asked to confirm that they were over 18, and that they fell (or had within the last two years fallen) into at least one of the categories of relevant stakeholders we sought to include:

* users of maternity services in England, such as mothers, parents or birth partners;
* those employed as clinicians working in maternity services in England;
* those employed as a managers or administrators working in maternity services in England;
* those employed in roles relating to the commissioning of maternity services in England;
* those employed in senior leadership roles in healthcare organisations that provide maternity services in England (including NHS organisations and independent-sector providers);
* those involved in roles relating to maternity policy and regulation in national bodies in England (e.g., NHS England, Department of Health and Social Care, CQC itself, other regulators);
* those involved in organisations that campaign or lobby around maternity care in England (e.g., charities and campaigning organisations).

Data were analysed using descriptive statistical methods, and content and thematic analysis for free-text responses.

## Results

### The profile of respondents

The 215 respondents came from across the seven roles listed above. The largest group of respondents were those identifying themselves as maternity service users (74), followed by clinicians working in maternity services (66). Much less well represented were those in management, administrative and commissioning roles. Less than half of respondents declined to supply optional information on their demographic characteristics. Those who did were predominantly female (93%), predominantly white (93%), largely not affected by a disability, impairment or long-term health condition (85%), and aged between 36 and 55 (58%). No information is available on the remaining participants.

### Views on the revised For Us framework as a whole

Overall, respondents were positive about the framework. Asked how well they thought the “eight features reflect your view on ‘what good looks like’ for maternity service users and staff”, 65 per cent responded ‘to a very great extent’ or ‘to a great extent’ (Figure 1). Only four per cent responded ‘to a little extent’ or ‘not at all’. Views varied slightly between groups: for example, maternity service users were slightly less positive about the framework than clinicians, with 54 per cent responding ‘to a very great extent’ or ‘to a great extent’ to this question.

Free-text comments on the framework reflected this distribution. Some felt that the framework was a little too abstract and lacked humanistic language in places, and that it might make more of the importance of the maternity service user—and/or specifically refer to women and mothers, not just service users.

A notable point of contention for some of the respondents who provided free-text comments on the eight features as a whole was the reference to “shared decision-making.” This was seen by some as outdated, excessively paternalistic, legally outmoded (particularly in light of the Montgomery versus Lanarkshire ruling, which established that patients should be told whatever they want to know and that doctors have a duty of care to warn of material risks of treatment) 34 and potentially disempowering in relation to decisions that should not be shared, but woman-led.

Respondents also emphasised the importance of sufficient funding to realise the principles set out in the framework in practice. Some felt that more might be done to place maternity services in their wider service-delivery context, noting the interdependence between maternity care narrowly defined and wider perinatal pathways (including shared resources, such as staff and facilities, and shared responsibility for outcomes: the determinants of maternal safety were not to be found solely during labour and birth).

### Views on the specific features of the revised For Us framework

Most respondents (162, 75%) also considered one or more of the individual features. Most of these responded to a question regarding whether the feature should be ‘included as is’, ‘included with amendments’, or ‘excluded’ from a future learning resource. Many also provided free-text comments on the features, and on the reasons for their response to the question regarding inclusion or exclusion.

Table 2 shows the proportion of participants responding ‘include as is’, ‘include with amendments’ and ‘exclude’ for each feature. In all cases, the majority selected ‘include as is’, though the size of the majority varied; across the board, only a very small number of respondents suggested that any feature should be excluded.

**Table 2.** Responses on whether each feature should be ‘included as is’, ‘included with amendments’ or ‘excluded’.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Feature | Include as is (%) | Include with amendments (%) | Exclude (%) | Total number of respondents |
| 1. Commitment to safety and improvement at all levels, with everyone involved | 58 (56%) | 46 (44%) | 0 (0%) | 104 |
| 2. Technical competence that is attentive to diverse health needs and supported by formal training and informal learning | 55 (59%) | 37 (40%) | 1 (1%) | 93 |
| 3. Optimised teamwork, team communication and coordination | 57 (60%) | 38 (40%) | 0 (0%) | 95 |
| 4. Constant reinforcing of inclusive, respectful and ethical behaviours towards all colleagues and all maternity service users | 55 (56%) | 43 (43%) | 1 (1%) | 99 |
| 5. Clear, respectful communication and shared decision-making with maternity service users that is culturally competent and accounts for diversity | 53 (56%) | 42 (44%) | 0 (0%) | 95 |
| 6. Multiple problem-sensing systems, used as basis of action, and supported by active nurturing of the conditions for psychological safety | 59 (70%) | 24 (29%) | 1 (1%) | 84 |
| 7. Structures, systems and processes designed for safety and regularly reviewed and optimised, guided by human factors / ergonomics principles where appropriate | 67 (74%) | 23 (26%) | 0 (0%) | 90 |
| 8. High quality leadership and management | 47 (53%) | 42 (47%) | 0 (0%) | 89 |

Comments on each feature were wide-ranging and sometimes disparate, but for each feature, some common themes could be identified. Themes that appeared most prominent for each feature were as follows.

* **Commitment to safety and improvement at all levels, with everyone involved:** Some respondents felt that safety needed to be more explicitly defined, especially given the range of ways in which the term can be used—some of which might be in tension with one another. Some suggested that more might be done to explain *why* safety needed to be prioritised in this way. Some respondents also highlighted the importance of explicitly identifying the role of the service user in contributing to safety.
* **Technical competence that is attentive to diverse health needs and supported by formal training and informal learning:** Some respondents found the language used in this feature a little vague, querying for example the apparent distinction between clinical and technical skills. The importance of resourcing was again a strong concern for respondents, who highlighted that training and development of staff needed to be seen as essential to a safety-critical activity, not an optional bolt-on. Respondents made various suggestions for training activities that might be cited in this feature.
* **Optimised teamwork, team communication and coordination:** Resourcing was again seen as crucial by several respondents. Some suggested that the feature needed to be explicit about the scope of the team, ensuring it extended to groups such as paediatricians, as well as to senior leaders.
* **Constant reinforcing of inclusive, respectful and ethical behaviours towards all colleagues and all maternity service users:** Respondents endorsed the importance of this feature and noted that achieving it would be a long-term challenge, given what was seen as a prevailing culture of low morale and sometimes bullying behaviour in many teams. Respondents were split regarding the emphasis in the feature on racism (over other forms of discrimination and oppression, such as misogyny and heteronormativity). Some respondents felt that the language relating to respect for mothers and parents’ beliefs and culture should be strengthened.
* **Clear, respectful communication and shared decision-making with maternity service users that is culturally competent and accounts for diversity:** In line with comments on the framework as a whole, some respondents expressed concern about the language of ‘shared decision-making’ (see section 5.2.2 above). Relatedly, respondents made suggestions about how best to support informed decision-making, including the provision of information, empowerment and consent.
* **Multiple problem-sensing systems, used as basis of action, and supported by active nurturing of the conditions for psychological safety:** Relatively few respondents commented on this feature, but among those who did, there was some concern about the clarity of language used—particularly the notion of ‘problem-sensing systems’ itself. Some respondents worried about potential unintended negative consequences of encouraging multiple systems for detecting problems; others highlighted the need to explicitly include transparency with and accountability to service users in the feature.
* **Structures, systems and processes designed for safety and regularly reviewed and optimised, guided by human factors/ergonomics principles where appropriate:** Along with feature 6, this feature attracted fewer responses than most, and many of them were supportive of the importance of taking a human factors-informed approach to improving socio-technical systems and making the right thing the easiest thing to do. Some were keen to stress that professional judgement and flexibility were likely to remain crucial components of safety since infallible systems were a long way from being achieved.
* **High quality leadership and management:** Respondents emphasised the importance of role-modelling and listening behaviours in this feature, and wondered if they could be more explicitly foregrounded. The role of leaders in championing maternity services at the top of organisations was highlighted by some. Others suggested that the value of supporting the wellbeing of managers and leaders might be included.

Across features, recurrent themes could be identified in the comments. Ensuring explicit reference to the service user (and more specifically to the woman or person in labour) was a common refrain, as was concern about the degree to which these ideals would be achievable given resourcing constraints. An associated concern was that some features at least could be subverted for use as performance management or regulatory ‘sticks’.

## Conclusion

The survey attracted interest from stakeholders with a wide range of interests in maternity care, with maternity service users and clinicians particularly well represented. Overall it provided a good level of endorsement of the revised For Us framework, with the majority of respondents feeling that it reflected ‘what good looks like’ well, and that individual features were valuable and should be included.

Along with the participatory workshops (Chapter 7), the data collected in this survey offer both affirmation and critique of the features of the learning resource. The way in which we sought to integrate them into the next iteration of the learning resource is described in Chapter 2. We did not attempt to incorporate every suggestion into this iteration of the learning resource, and do not have space to fully justify our reasons for accepting or discarding each one of the suggestions made. We have attended in particular to those suggestions that reflected widespread views among respondents, to those that picked out obvious shortcomings in the earlier version of the framework, and to those that highlighted important issues that were not fully addressed in the literature that informed the For Us framework.

We note also some limitations of the survey. We did not obtain data on socio-demographic characteristics for a large proportion of the sample as respondents chose not to provide it, and those who did report these variables were predominantly white. The sample size, while reasonable for an exercise of this scale, is limited.

There may be some value in subjecting the suggestions made by respondents in the survey to a further exercise in validation and prioritisation. For example, a consensus-building or priority-setting exercise may offer a wider perspective on the relative importance of the many suggestions made.

# Concluding remarks

In this final brief chapter, we review the contributions of the study as a whole. We identify key points arising in relation to each of the evaluation’s first objective, and suggest potential next steps.

## Summary of the work of the evaluation

Spanning a 10-month period from May 2023 to February 2024, our evaluation encompassed six workpackages that used mixed methods to achieve its objectives, plus final integrative activities to bring learning from the workpackages together and produce a further iteration of a ‘learning resource’ for CQC and other stakeholders that seeks to encapsulate ‘what good looks like’ for maternity service users and staff. This report focuses on the first objective of the study: to characterise what good safety culture looks like in maternity and the factors underpinning it.

The outcome – the learning resource – was presented in Chapter 2. Later chapters described the work that went into developing it, particularly reviewing the existing literature on safe, high-quality maternity cultures and the needs and experiences of minoritised service users (Chapter 3), participatory workshops to elicit views of maternity service users on a revised version of the For Us framework (Chapter 4), and a consultation survey of the breadth of stakeholders with an interest in maternity care on the same revised For Us framework (Chapter 5).

## The learning resource: potential value and next steps

The final iteration of the learning resource we present in Chapter 2 integrates the insights of multiple affected stakeholder groups to present a rich, evidence-informed, and balanced picture of what good looks like in maternity care. Thanks to a comprehensive review of the literature and the judicious use of mixed methods to seek the insights of a range of stakeholders, including those whose views have often been systematically ignored, it incorporates multiple perspectives on what really matters and what that looks like in practice. It is not perfect. Some suggestions from stakeholders were more readily incorporated into it than others, and the sheer volume of ideas that came through the survey meant that not all could be incorporated.

Further work may be beneficial in further enhancing and optimising it. For example, the features themselves or the candidate items within them could be subject to a formal consensus-building or prioritisation process, as suggested in Chapter 5. Some potential end users will undoubtedly find more value in some features and items than others.

**It is not intended that the resource should be used in a prescriptive way, as a framework for inspection, or as a list of items to tick off: the dangers of such an approach are well described in the companion report addressing the evaluation’s second objective, and by many survey respondents in Chapter 5.**

The learning resource is also somewhat “raw” in character at present. By this we mean that it seeks to describe the elements and features of high-quality care but does not in itself constitute a tool for achieving them, monitoring them, regulating them, quality-assuring them, and so on. As described in section 1.3.2, early discussions with CQC indicated that what was needed—and what was more realistic given the scope of the study—was a resource that could speak to multiple parties by articulating a common vision of what good looks like, and so ensure that they were working from a common starting point, so that service users, professionals, managers, organisations and regulators alike would be aligned in their understanding of high-quality maternity care. Clearly this does not in itself guarantee that conflict over quality, over how to assess quality, and over the validity of assessments of quality will be avoided. However, we believe it does offer an important step towards achieving clarity of shared vision, and thus alignment of activity.

# Appendix: ‘Version 2’ of the For Us framework (update of Version 1 based on literature review only)

This appendix presents the interim ‘version 2’ of the For Us framework, based on the literature reviews described in Chapter 3 (workpackage A), which formed the basis of the workshops and consultation survey undertaken in workpackages B and C (Chapters 4 and 5). It is superseded by the learning resource presented in Chapter 2.

1. **Commitment to safety and improvement at all levels, with everyone involved**: This feature was identified in the original For Us framework as a defining feature of ‘what good looks like’. It remained intact in version 2.
2. **Technical competence that is attentive to diverse health needs and supported by formal training and informal learning**: In the original For Us, we identified an insistence on technical proficiency as a key feature of maternity unit safety. It is a similarly key feature of version 2, but was updated to emphasise that technical competence must be attentive to diverse health needs. Similarly the underpinning description of ‘what good looks like’ provided concrete examples of what is needed to ensure inclusiveness (e.g. ensuring recognition of variations in effectiveness of monitoring and risk assessment tools by skin tone, and adapting training and practices accordingly).
3. **Optimised teamwork, team communication and coordination**: The original For Us framework identified teamwork, cooperation and positive working relationships as key features of safety in maternity units. It is retained as an indispensable feature in version 2, and combined with the original feature relating to “effective coordination and ability to mobilise quickly” given the overlap between the two features.
4. **Constant reinforcing of inclusive, respectful and ethical behaviours towards all colleagues and all maternity service users**: In the original For Us, we found that an important characteristic of safety on maternity units involved clearly articulated and constantly reinforced standards of practice, behaviour, and ethics. In version 2, we extended this feature to emphasise the need for inclusiveness and respect for diversity. We also further emphasise the need for inclusive and respectful behaviours towards all colleagues and all maternity service users. As with feature 2, this is illustrated in the full description of the feature with examples of the active steps that services must take to avoid stereotyping, miscommunicating, or otherwise failing to recognise and meet the diverse needs of maternity service users.
5. **Clear, respectful communication and shared decision-making with maternity service users that is culturally competent and accounts for diversity**: This feature represents a marked shift from the original For Us framework, which did not include a specific feature on communication and shared decision-making. The importance of foregrounding such work strongly emerged as a feature of safe maternity culture from both of our literature reviews. The feature therefore highlighted the need for inclusive, sensitive communication tailored to the needs of all groups, ensuring that people understand the information provided, have time to make an informed decision, and feel safe in communicating their needs and concerns.
6. **Multiple problem-sensing systems, used as basis of action, and supported by active nurturing of the conditions for psychological safety**: The original version of For Us identified the importance of monitoring multiple sources of intelligence as a feature of maternity unit safety. Our extended analysis reaffirmed the importance of this, strengthened by further emphasis on nurturing the conditions for psychological safety and the need to ensure that data collection and analysis systems are informed by data that appropriately account for socio-demographic characteristics and access diverse perspectives. The underpinning description of ‘what good looks like’ elaborates the various forms that data can take, including ‘hard data’ and soft intelligence, including their relative strengths and fallibilities.
7. **Structures, systems and processes designed for safety and regularly reviewed and optimised, guided by human factors/ergonomics principles where appropriate**: The original For Us framework stressed that optimised systems and processes are a key feature of safe maternity services. Version 2 further emphasises the importance for safety of the structural dimensions of maternity services and the importance of operational fitness, underpinned by sound use of human factors/ergonomics principles.
8. **High quality leadership and management**: This eighth feature was not included explicitly in the original For Us framework, but threaded throughout the other features. In version 2, we identify it as a distinctive feature in its own right, reiterating the many elements of high quality leadership and management that are implied or described under other features, and consolidating them in one place.

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