how to fix

and improve maternity safety

Royal College of Midwives

The challenge

Safe, good quality care should be the expectation and the requirement of every maternity service throughout the UK. That is why the Royal College of Midwives (RCM) not only wants maternity services that meet the needs and choices of women in how they birth their baby but also maternity services that are safe.

Maternity safety is a very broad and important topic, with large amounts of work currently being undertaken to improve it. In this short guide, we have not attempted to provide a comprehensive survey of that work or an overly detailed prescription for every step to improve safety. Instead, this guide aims to outline the key issues and the most important potential solutions.

Quality and safety are imperative in maternity services. However, we know from a number of reports over the past Parliament, including those from the Care Quality Commission, that the high standards we seek to uphold have not always been met.

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The recommendations made by these reports have been welcomed by the RCM, and some progress has been made since their publication. However, that progress needs to be accelerated, and confidence in maternity services, not just within those communities but across the population and the profession, must be restored. The steps required are not complex in themselves, but they do require a commitment from the next government to address them, and at pace. A failure to do so risks leaving even more women and families at risk of unsafe care and the devastating consequences that follow. It also comes as a considerable financial cost for the NHS, with compensation payments rising from £460 million in 2016 to more than £1 billion in 2023, equivalent to third of the total maternity budget.

The solutions

1. Break down barriers between staff groups

The first is the need to break down barriers between different staff groups, that all too often has resulted in silo working, unacceptable behaviours and, ultimately, poor outcomes for women and families. Improving interprofessional relationships leads to better trust, understanding and communications between midwives, obstetricians and other members of the maternity team. This can be done, for example, through more multi-disciplinary learning – midwives, obstetricians and others training together as much as possible. They work together, so they should learn together. That needs to be the norm.

Improving interprofessional relationships leads to better trust, understanding and communication

2. Staff shortage leads to fatigue

Staffing shortages compromise safety. That has been highlighted not just by the RCM but by the reviews mentioned earlier into failures in maternity services. And the NHS is short of midwives, with our estimate being that in England alone the NHS is short of 2,500 midwives. While not as severe as England, services in Scotland, Wales and Northern Ireland have their challenges too.

The impact of this was highlighted by the survey conducted by the RCM during one week in 2024, which found that, in just seven days, UK midwives and MSWs worked around 145,000 hours' unpaid overtime. That is what a shortage of midwives means in practical terms, and we set out how to fix the midwifery staffing crisis in a report published in February 2024.

This level of overwork goes hand-in-hand with the numerous accounts we hear of midwives feeling uncared for at work – unable to take breaks, sometimes even unable to get a drink of water or go to the toilet. It is also leading to fatigue, and fatigued workers more easily make mistakes. In healthcare, mistakes can have incredibly serious, lifechanging consequences. To combat overwork and fatigue, we need to see an end of the midwife shortage but, in the short term, maternity staff must be enabled to take breaks. This is a safety issue more than anything else. The level of overwork highlighted in our survey needs to be monitored as a matter of routine by the NHS, locally and nationally, as a safety-critical issue.

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3. Greater oversight by executive boards

This highlights just one area where the NHS should have more focus on how maternity services are faring. At a local level, NHS Trust and Board executive boards need to place more emphasis on what is happening with their local service. Executive boards need to be much more effective in interrogating the data they receive from the frontline, enabling them to act early and learn from mistakes quickly. Additionally, senior midwives should be legally empowered to cut through and go directly to their local board with any safety concerns.

We need NHS staff to feel more confident that they can speak out and that they will be listened to if they have safety concerns. That may require new legislation; it certainly requires continued effort to change the culture of the NHS.

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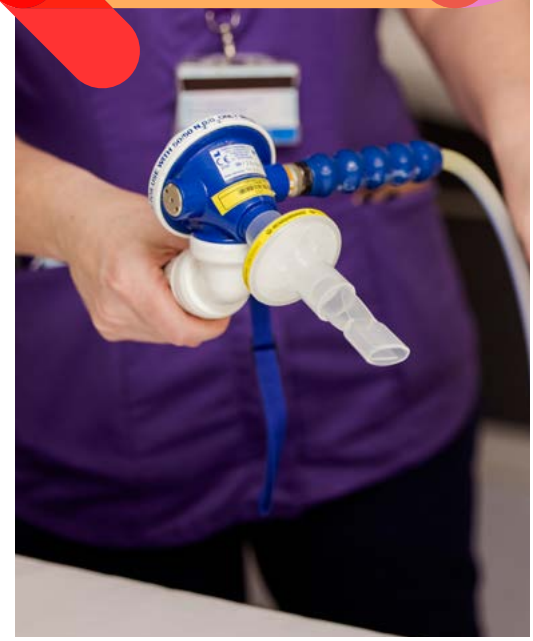
4. Protected time for maternity staff to train

Staff shortages also mean that sometimes midwives must postpone vital training, leaving them potentially less prepared than they should be for emergency situations. It is imperative – if we want a safe service – that maternity staff have enough time to train, learn and improve their knowledge and skills, and to do so together.

Staff shortages mean that sometimes midwives must postpone vital training

5. Investment in infrastructure and equipment

Safety is not just about staffing, crucial though that is. All too often the best efforts of maternity staff are undermined, and the safety of women and families endangered, by ageing and crumbling hospitals, substandard facilities and a lack of equipment or equipment that is faulty or unusable. We need to see a clear commitment to invest more in up-to-date equipment and infrastructure too, including the buildings from which services operate.



Conclusion

To fix and improve maternity safety, the next government must:

1. Break down barriers between staff groups – normalise them training as one team.
2. Ensure there are the right staff in the right place at the right time to ensure people are able to take breaks and don't need to work beyond their hours.
3. Ensure that local NHS boards stay on top of what is happening in their maternity units, with senior midwives having direct access to them and frontline staff able to raise issues and concerns without fear of retribution.
4. Eliminate the midwifery staffing shortage once and for all.
5. Invest in estate, facilities and equipment that are compliant with national standards and fit for purpose.

The RCM actively contributes to discussions and advice about maternity safety, including issuing our own guidance and collaborating with partners on safety programmes.

For more information about the role of the RCM or if you would like to discuss specific maternity safety issues, please contact stuart.bonar@rcm.org.uk.

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