Position statement: Maternity Safety

This statement sets out the RCOG's position and recommendations on the priority areas for change across NHS England and UK Government policy to improve maternity safety.

RCOG involvement in maternity safety

The College supports maternity safety within the system through its role as an educator: developing the curriculum, raising standards of care through the development of clinical guidance, supporting the career development of clinicians through exams, professional development courses and events, and support services for its members. The College also delivers research and quality improvement programmes that contribute to improvements in maternity safety and as part of its influencing and advocacy activity, ensures system wide improvements are identified and delivered. The College does not have the levers to directly change how services are designed and delivered, not does it have a role in the inspection and regulation of services.

The Avoiding Brain Injury in Childbirth (ABC) programme is designed to reduce the risks associated with two key contributors to avoidable brain injury: managing impacted fetal head at caesarean birth and recognising and responding to the baby who may be deteriorating during labour.

It is based on the principle that evidence-based, co-designed patient-focused standardisation of clinical practice can reduce unwarranted variation and improve care and outcomes. Crucially, this needs to be supported by comprehensive improvement resources, including training, tools and assets to enable good clinical practice and teamwork and respectful and inclusive communication and decision-making with women and birth partners.

One of the key learnings from the project is that implementation of improvement programmes takes intention, evidence-based approaches and sufficient funding. Models like the ABC programme epitomise the time and investment required to bring such important interventions into everyday practice.

The programme was being rolled out to units in autumn 2025 and will help staff improve practices and strengthen efforts to prevent brain injuries in childbirth. The College would like to see more investment in programmes like ABC, that can make a real difference to improving outcomes for babies.

The College has updated its Framework for Maternity Service Standards, which sets out high-level service standards for commissioners and service providers aimed at improving outcomes and reducing variation in maternity care. The Standards include a new section on cross-cultural communication and the provision of professional interpretation services, to

ensure that maternity care is safe, inclusive and responsive to the diverse needs of women and families.

The RCOG has established the RCOG Maternity Safety Research Centre in partnership with the University of Birmingham, which will improve maternity safety by addressing identified gaps in research and exploring how digital technology, like AI, can enhance patient care.

The College is developing a new Good Practice Paper - Restorative approaches to healthcare harm - which will be completed in 2026. It will explore how to create a safe, respectful environment for all parties to communicate about an event, focusing on repairing relationships and meeting needs rather than just assigning blame.

The RCOG has developed a set of free, comprehensive race equity modules for doctors and trainees across O&G, offering practical tools to deliver meaningful change. The learning modules support inclusive training, challenge bias, improve communication and empower RCOG members to ensure equity across clinical practice.

Upstream investment

In order to avoid further poor outcomes and support services to make meaningful improvements to safety and care, upstream investment is required.

There is broad consensus that funding for maternity services remains significantly below the level needed to support improvements in quality and safety. In 2021 the Health and Social Care Committee recommended £250-300m additional funding every year for maternity services in England, highlighting that this was the minimum increase needed to ensure safe care. This was subsequently endorsed by the 2022 Ockenden Review.

Since 2021 there have been several funding announcements. Between 2021 and 2024 an additional £165 million a year was provided to improve maternity and neonatal care. This rose to an additional £186 million a year from 2024/25, directed towards increasing frontline workforce numbers, supporting initiatives including bereavement care, time for obstetric leadership, and supporting a range of projects including a culture and leadership programme, and staff retention. The 2024 Spring Budget included a further £35 million over three years.

Whilst all investment is welcome, it is still insufficient. Given the high rate of inflation since the Health and Social Care Committee recommended £250-£300 million per year as a minimum, even this is now likely to be insufficient to achieve the transformative change needed.[i]

In addition to insufficient funding overall, the transfer of previously ringfenced maternity service development funding of £90m into core ICB budgets in 2025-26 poses a real risk that vital resource will be diverted away from maternity, due to ICB deficits and competing demands.

Ensuring the long-term sustainability of maternity services requires moving away from short-term funding towards multi-year funding settlements.

NHS Digital figures show an increase of O&G doctors across all grades – numbers have grown from 5,568 FTE staff in July 2015 to 7,678 in July 2025. Yet despite this increase, medical staffing feels insufficient on the frontline. Staff feel unable to cope with demand. This has been attributed to a variety of reasons including the increasing complexity of care required, the loss of administrative staff, and unequal distribution of posts across the country.

More than half of women having a baby now do so with some doctor-led medical intervention, such as a caesarean section or the use of instruments such as forceps or a ventouse suction cup.[ii] This is driven by women being older, and higher levels of obesity, maternal diabetes and pre-existing medical conditions.

More complexity means women are more likely to need obstetric-led care throughout their pregnancy and labour. It also means longer theatre times for caesarean births, and a higher level of obstetric skill. This is difficult for the current workforce to manage while they are also covering rota gaps, fulfilling leadership roles or trying to access learning.

Staff at all levels do not have time to focus on safety improvements and learning, due to the pressures of service delivery. Multidisciplinary training is vital for creating open, supportive cultures where teams work and learn together, but many teams are unable to take time away from service delivery to attend training because they cannot find backfill.

RCOG members are telling us loud and clear that the current pressures are unsustainable. The RCOG 2025 workforce census showed O&G doctors are being driven out of the profession by the daily pressure of staff shortages, working beyond their hours and the reality of knowing that despite their best efforts, the quality of care women receive is being impacted.

Nearly two thirds of doctors who responded (65%) are at risk of burnout. One in five (19%) intend to leave in the next five years, linked to burn out, work-life balance, staffing shortages and working conditions. Sixty-eight per cent always or often work beyond their contracted hours.

The steady increase in medical intervention, including caesarean birth, is not in itself necessarily a cause for concern, but services need support to adapt and ensure they have the right staffing, training and facilities to manage increasingly complex births. Without this support and investment in the workforce, it will be much more difficult to make meaningful improvements to safety and care.

The Government must incorporate the impact of the changing trends in maternity care and outcomes when reviewing and planning maternity services. This information should be used

to anticipate and respond with appropriate allocation of resources, such as workforce, the number of beds and/or cots available and obstetric theatre capacity.

If governments, policy makers and commissioners do not invest in plans that increase workforce numbers and prioritise flexibility, training, career development and wellbeing, we will continue to lose skilled clinicians from the profession and find it increasingly difficult to attract the next generation. Women and girls will pay the price.

The maternity estate is in dire need of investment. Women and RCOG members have told us anecdotally that units are outdated, with peeling paint, collapsing ceilings, and insufficient space. Some consultation rooms are too small to comfortably accommodate both the woman and the midwife and also lack space for essential equipment. Access to appropriate facilities for families who have experienced a bereavement varies across services.[iii]

The Government's recent Maternity and Neonatal Estates Review found a clear link between the condition of service infrastructure, the experience of service users and staff, and safety. Forty-three per cent of the maternity and neonatal estate does not meet basic levels of health and safety compliance. Significant clinical time is lost to estate-related issues, such as power outages, water leaks and faulty nurse call systems. This puts additional pressure on already stretched staff to provide high-quality and safe care and can directly lead to procedures delays, such as planned caesarean births.

NHS England has said it will support allocation of capital funds to trusts to address critical infrastructure risks within their maternity and neonatal estate and start work to modernise technical design standards to incorporate new clinical models and other changes aligned with new building programmes.

Trust boards have been asked to review their estate data and seek assurance that all healthcare premises, from which they are delivering maternity services, are of appropriate standard and take mitigating action if they are not. This is an urgent problem and we must see improvements soon.

Population health and maternity

Women who are in good health have a better of chance of becoming pregnant, having a safe and healthy pregnancy and giving birth to a healthy baby, while poorer general health linked to poverty and deprivation can lead to increased risk of adverse pregnancy outcomes.

Women from deprived areas of the UK are more likely than those in less deprived areas to die during or shortly after pregnancy, and this disparity has increased in recent years.[iv] Research has attributed 24% of stillbirths in England to socioeconomic inequality[v], and reductions in the national stillbirth rate in recent years have been more marked in the

least deprived areas.[vi] Women from Black ethnic backgrounds are three times more likely to die during or shortly after pregnancy compared to white women.[vii]

Racial and ethnic inequalities have been evidenced in rates of miscarriage, emergency caesarean birth, pregnancy-related complications such as hypertension in pregnancy and gestational diabetes, and pre-existing conditions associated with adverse pregnancy outcomes.[viii] Significant variation by ethnicity has been found in access to perinatal mental health services in England.[ix] Babies from Black and Asian ethnic groups are more likely to be born prematurely[x], and stillbirths among babies from Black and Asian ethnic groups are consistently higher than their white counterparts.[xi]

Effective communication is fundamental to safe maternity care. However, access to high-quality, timely interpretation and translation services remains inconsistent across maternity services. Women with limited English proficiency may struggle to communicate symptoms, preferences or concerns, and may not be fully involved in decision-making. In high-risk or emergency situations, lack of professional interpretation can lead to delays, miscommunication and avoidable harm. The overuse of family members, including partners or children, to interpret raises safeguarding and confidentiality concerns and can undermine informed consent.

Failures in communication have been repeatedly highlighted as contributory factors to serious incidents and subsequent litigation. Ensuring equitable access to funded professional interpretation services, including in-person, remote and out-of-hours support, must be recognised as a core component of safe maternity care and embedded into workforce planning and service commissioning.

We welcomed the Government's manifesto commitment to set an explicit target to close the Black and Asian maternal mortality gap, which we have recommended for several years. We know the targets are being developed – it is imperative that they are implemented urgently. Targets must be supported by substantial ring-fenced funding and co-produced with ethnic minority women and communities.

We recommend that the Government considers also setting a target to end the higher risk of maternal mortality for women living in more deprived areas.

[i] Sands and Tommys Joint Policy Unit Investment-in-maternity-and-neonatal-services (2024)
[ii] National Maternity and Perinatal Audit, *State of the Nation Report 2023* (2025)
[iii] Care Quality Commission, National review of maternity services in England 2022 to 2024 (2024)
[iv] MBRRACE-UK, *Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20* (2022)
[v] Jardine J et al, *Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study,*(2021)
[vi] Jardine J et al, *Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study,*(2021)
[vii] MBRRACE-UK, *Data brief: Maternal mortality UK 2020-22* (2024); Knight M et al, *A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality* (2022)
[viii] NMPA, Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies (2021); Tommy's, The risk of miscarriage for Black and Black Mixed Heritage women (reviewed 2022); Quenby S et al, Miscarriage matters: the epidemiological, physical, psychological, and economic costs of early pregnancy loss Lancet (2021)
[ix] Jankovic J et al, Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities—a population-based study BMC Medicine (2020); Pilav S, A qualitative study of minority ethnic women's experiences of access to and engagement with perinatal mental health care (2022)
[x] ONS, Birth characteristics in England and Wales: 2021 (2023); NMPA, Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies (2021)

[xi] ONS, Birth characteristics in England and Wales: 2021 (2023); NMPA, Ethnic and Socio-economic Inequalities in NHS Maternity and Perinatal Care for Women and their Babies (2021); MBRRACE-UK, MBRRACE-UK perinatal mortality surveillance UK perinatal deaths of babies born in 2022 (2024)