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Safeguarding mothers and babies

Carla Avery and colleagues discuss the urgent reforms needed in maternity services, based on the Care Quality Commission's maternity services report the Care Quality Commission's (CQC, 2024) maternity services report in 2022–2024 marked a critical juncture in evaluating the state of maternity services across England. With increasing scrutiny on patient safety, quality of care and the wellbeing of mothers and babies, the report highlighted pressing concerns and areas for improvement. This article provides a critical commentary on the report's findings, with a particular focus on patient safety, leadership, workforce disparities, mental health and actions that can be taken to address these issues. We use the terms 'woman' and 'women' to reflect the identities of the majority accessing maternity services, while acknowledging that individuals of diverse gender identities may also require these services. Addressing systemic issues in patient safety

One of the foremost concerns in the CQC (2024) report was patient safety, where the need for systemic improvements in maternity units was evident. The report documented inconsistencies in care quality and highlighted issues in staffing and expertise as major risk factors. Inadequate staffing, specifically midwifery shortages, remains a longstanding issue, putting pressure on existing teams, limiting personalisation in care and sometimes causing critical delays in intervention during labour and birth (Baby Loss and Maternity All Party Parliamentary Groups, 2022). The Royal College of Midwives (2022a) reported a national shortfall of around 2000 midwives in the NHS in 2022. While a 2.4% increase in the number of midwives has since been reported (NHS England, 2024), there is still an increasing number of midwives leaving the register (Nursing and Midwifery Council, 2024) and the Royal College of Midwives (2023) has suggested the number of midwives is still low in comparison to the number of births. This shortage poses a direct risk to the quality of care, particularly for women with complex or high-risk pregnancies. Both the Royal College of Midwives (2022b) and the CQC (2024) advocate for greater investment in midwife recruitment and retention to ensure safer, more reliable care.

Enhancing leadership to enable a culture of accountability Leadership challenges were also flagged in the CQC (2024) report. In numerous cases, leadership teams were seen as disconnected from the daily operations of their units. The Ockenden (2022) review of maternity services in Shropshire similarly identified inadequate leadership as a root cause of care deficiencies.

Poor leadership can create fragmented care, insufficient oversight and a lack of immediate problem resolution.

Effective leadership requires a culture of accountability and continuous improvement. A 'blame-free' environment, in which staff feel safe to report incidents, is crucial for quality improvement.

However, the CQC (2024) report noted that some staff refrain from reporting concerns for fear of repercussions, which stifles efforts to implement systemic changes.

Integrating service user feedback as part of leadership strategies is essential. Consistent feedback from mothers and their families helps align maternity services with patient expectations. In units serving diverse communities, prioritising feedback is especially important to bridge cultural and linguistic barriers that may impact care.

Addressing persistent disparities in maternity care Equity in maternity care remains a major issue, with significant disparities for women from ethnic minority backgrounds and socioeconomically disadvantaged areas.

The CQC (2024) report reflected ongoing inequities, with these groups experiencing adverse outcomes at disproportionately higher rates. MBRRACE-UK (2021; 2022; 2023; 2024) reports repeatedly indicate that Black and Asian women face significantly higher risks of maternal and neonatal mortality compared to their White counterparts. To address these disparities, the CQC (2024) called for more targeted interventions, including community outreach and culturally competent care, which ensure respect for diverse cultural needs and improve patient satisfaction and outcomes. The Royal College of Obstetricians and Gynaecologists (2019) has also advocated for services tailored to minority groups, emphasising language support and translation services for women with limited English proficiency.

Improving mental health support for new mothers The mental health of mothers, both during pregnancy and postnatally, is a growing priority in maternity care. The CQC (2024) report highlighted that mental health support is often inadequate, with long waiting times for referrals and limited resources in many units. The NHS (2019) long term plan outlined intentions to expand perinatal mental health services, but progress has been slow. The CQC (2024) advocated for integrated care pathways between maternity and mental health services to ensure comprehensive support for mothers who may experience perinatal depression or trauma. Early recognition of mental distress and timely referrals are essential. Training maternity staff to detect signs of mental health issues is crucial, enabling timely and appropriate care for affected mothers.

Buckinghamshire New University's approach At Buckinghamshire New University, the midwifery programme is designed to prepare graduates for these realities by embedding self-care as a core practice. Encouraging midwives to prioritise their own wellbeing supports a sustainable approach to patient care, addressing some systemic concerns raised in the CQC (2024) report. Self-care in midwifery is fundamental to providing safe, compassionate care. The university's work in decolonising the curriculum prepares students to recognise and address inequalities highlighted in this article. Through targeted sessions on mental health and cultural competence, we aim to produce graduates equipped to effect change in maternity care. This approach aligns with broader goals to ensure future midwives can tackle the disparities and challenges detailed in the CQC's (2024) findings.

Conclusions

The CQC report presented a candid examination of the current challenges in maternity care across England. Urgent reforms are needed, particularly in staffing, leadership and equitable care provision. Without addressing midwifery shortages and training gaps, maternity services will continue to face significant challenges. Effective leadership should cultivate a culture of accountability, valuing feedback and fostering a learning environment. Addressing disparities in care for minority groups and socioeconomically disadvantaged communities remains a priority. Integrating mental health support into maternity care pathways is also essential to meet the comprehensive needs of mothers. This report should act as a catalyst for change, compelling NHS leaders and policymakers to implement the CQC's recommendations for the betterment of maternity services. BJM

Self-care in midwifery is fundamental to providing safe, compassionate care

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